Tri-County
Community Action Agency
*Helping people. Changing lives.*

1126 Hartford Avenue
Johnston, RI 02919

**Phone:** (401) 519-1940
**Fax:** (401) 351-6613

# Authorization to Obtain and/or Release Confidential Information

**Client Name:** _____
First MI Last

**Address:** _____
Street City/Town/State Zip Code

**Date of Birth:** _____

**I hereby authorize Tri-County Community Action Agency to:**

❒ Obtain from: ❒ Release to: ❒ Consent to Fax ROI

**Name:** _____ **Agency**: _____

**Address:** _____
Street City/Town/State Zip Code

**Phone:** _____ **Fax:** _____

**Method of Release:** ❒ Verbal communication ❒ Written communication

**Information to Release/Request Includes:** (Check all that apply)

- ☐ Health Care Summary (Immunization, Lead, Pap Smear, Mammogram, Colonoscopy, Most Recent Physical, Medication List, Problem List,etc)
- ☐ All Medical Records
- ☐ All Dental Records
- ☐ All Behavioral Health Records
- ☐ Other (specify):_____

**Specify treatment dates for records to be released:**

From: _____To: _____

**Sensitive Information to Release/Request Includes**: (Check and initial all that apply)

- ☐ _____ Mental Health or Social Services
- ☐ _____ Substance Abuse
- ☐ _____ HIV/AIDS
- ☐ _____ Sexual Health Information

**This information is needed for the following purpose(s):**

- ☐ Client Care
- ☐ Client Request
- ☐ Transferring My Care
- ☐ Other: _____

I understand that my records are protected under RI General Law and cannot be disclosed without my written consent except as otherwise specifically provided by law. I am aware that I can refuse to sign this authorization. I also understand that if my records involve alcohol, drug abuse, or HIV (AIDS) testing, they are processed under Federal Regulation 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse, if relevant, and RI Public Law 88-405, Section 23.

I further understand that the released material may not be forwarded to any other entity other than the above designated person/place without my expressed, written permission, except as provided by law and will not be used for any type of marketing purposes. I understand that once my information is disclosed to the above authorized agency, Tri-County and its employees are not liable for the recipient's actions with regard to my information. Once this information is sent, it may no longer be protected by the federal rule on the privacy records.

**Unless revoked by the patient in writing, this authorization will expire one (1) year from the designated date signed by the patient below.**

_____ _____ _____
Signature of Client or legal guardian Relationship Date

_____ _____
Signature of Client under 18 (not required) Signature of Witness

Revised: 5/11/18