Southern New England Anesthesia and Pain Associates (SNAPA), 102 Smithfield Ave. Pawtucket, RI 02860. Fax: 401 729 6019

Authorization to release and disclose patient information

Patient Information	Name:_____ Date of Birth:_____ Address:_____ Phone: _____ City:_____ State:_____ Zip:_____
Clinic/hospital/Health care provider (Who has the information you want released?	Name:_____ Address:_____ Phone: _____ City:_____ State:_____ Zip:_____ Fax: _____
Receiving Party (Where do you want the information sent? Who may have the information?	Name:_____ Address:_____ Phone: _____ City:_____ State:_____ Zip:_____ Fax: _____
Information to be released (What do you want sent or released?)	Routine record sets (include dates of services_____) ☐ Clinic (Office visit, lab, radiology, medicines, immunizations) ☐Hospital (history and physical, discharge summary, operative reports, consultations, emergency, labs) ☐ Billing records ☐ Copies of films/images ☐ Any and all records (includes ALL types of records listed below. If you want to include images and billing records, check those boxes) Only records types checked below: ☐ Discharge summary ☐ Radiology reports ☐ History and Physical ☐Medication records ☐ Chemical dependency/substance abuse records ☐ Operative report ☐ Laboratory report ☐ Consultations ☐ Progress notes /clinic notes ☐ Mental health records
Release instructions (How and when do you want the information?)	Date information is needed:_____ (NOTE: PLEASE ALLOW 7-10 BUSINESS DAYS FOR PROCESSING) Release method / Format requested (check one) ☐ Paper ☐ Fax
Purpose of release (Why is it needed?)	☐ Continuing care ☐ Transfer of care ☐ Social Security appeal ☐ Insurance application* ☐ Personal use or review* ☐ Social Security disability determination* ☐ Insurance payment / claim ☐ Litigation/legal* ☐Other*_____ * Fees may be charges in accordance with law

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration date here _____
- This authorization may be cancelled in writing at any time. A cancellation will not change releases that happen before the cancellation. The SNAPA Notice of Privacy Practice describes how to cancel (revoke) this authorization
- SNAPA will not restrict my treatment if I choose not to sign this authorization
- A photocopy / fax of this authorization will be treated in the same was as an original
- SNAPA's records may include records that it received from other organizations. If these records have been used by SNAPA and filed in the record SNAPA maintains about you, these records may be released with your SNAPA records.
- SNAPA cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release SNAPA from any and all liability resulting from a re-disclosure by the recipient.
- Your signature indicates that you have read and understood this form, and authorize release of your information as described above.

_____ _____

Patient/legal Guardian Signature Date