East Bay Pediatric and Adolescent Medicine
234 Maple Avenue • Barrington, Rhode Island 02806-3406
(401) 247-1644 Fax: (401) 247-4961

AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION

(A copy of this authorization will be as valid as the original)

1. **I hereby authorize East Bay Pediatric and Adolescent Medicine to:**

❑ obtain my records from: ❑ to release my records to:

____
Name of physician, hospital, school, childcare and/or other

____
Street City State Zip Phone #

and I authorize the exchange of the following protected health, educational information from the records of the patient listed below. I understand that information exchanged pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. This release includes fax transmissions, phone conversations on portables or cell phones, and e-mail communication. I (we) understand the purpose for this release and that the information will remain confidential.

2. **Patient Name:** ______________________ **Date of Birth:** ____________

Address: ____
Street City State Zip

3. **Information to be disclosed to/from:** East Bay Pediatrics and Adolescent Medicine, Inc.
234 Maple Avenue, Barrington, RI 02806-3406

4. **Disclose the following information for treatment dates: Birth to Present**

❑ Complete Records	❑ Consult	❑ Physical Therapy	❑ Other ____________
❑ Discharge Summary	❑ X-Ray	❑ Emergency Reports	____________
❑ History & Physical	❑ Laboratory	❑ HIV	____________
❑ Outpatient Records	❑ Pathology	❑ Psychological	____________

5. **The above information is exchanged/disclosed for the following purposes:**

Diagnostic Evaluation/Care Coordination Transfer of Care

6. **I understand that I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice, childcare, school or other in writing, unless action has already been taken in reliance upon it, or during contestability period under applicable law.**

7. **This authorization expires on (upon)** ____________________(Insert applicable date or event)

8. ______________________________
Signature of Patient or Legal Representative

9. ______________________________
Date

____
Printed name of Patient or Patient's Representative

10. ______________________________
Relationship to Patient or Authority to act for Patient

IMPORTANT: This authorization shall be deemed invalid unless all numbered entries are completed.