Chad P. Nevola M.D., Inc.

AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION

This form may be used to authorize Chad P. Nevola, M.D., Inc. to disclose a patient's Protected Health Information (PHI). The form also includes information about your rights related to the release of PHI. **Please complete all fields. Incomplete or incorrect forms shall be deemed invalid.**

Patient Information – For individual requesting disclosure of their information.	
Name:	**Date of Birth:**
Street Address:	
City, State, Zip Code:	
Phone Number:	

Recipient Information – Patient hereby authorizes Chad P. Nevola, M.D., Inc. to disclose their information to the following individual/entity ("Recipient"):	
Individual/Entity Name:	
Street Address:	
City, State, Zip Code:	
Phone Number:	**Fax Number:**

Information to be Disclosed – Patient hereby authorizes Chad P. Nevola, M.D., Inc. to disclose the following information to the Recipient:

Dates of Services:	☐ All	☐ Specific dates of service: _________________________
Description of Information:	☐ Entire Record	☐ Other: ____________________________

Special Records: If you would like any of the following sensitive information to not be disclosed to the Recipient, please check the applicable box(es) below and initial next to the category of information.

☐ ______ Do not include drug and alcohol abuse records.
Initial

☐ ______ Do not include mental health records.
Initial

☐ ______ Do not include HIV/AIDS-related records.
Initial

☐ ______ Do not include sexual abuse/assault and domestic violence counseling
Initial

Purpose of the Release

☐ Coordination of Care	☐ Legal Matter
☐ Personal Use of Records	☐ Transfer of Care

Terms of this Authorization

Notice: Chad P. Nevola, M.D., Inc. and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal confidentiality laws, and may be subject to redisclosure by the Recipient.

My Rights: This authorization is voluntary. I understand I have the right to refuse to sign this Authorization and my refusal to sign will not affect my ability to obtain treatment. I understand I may revoke this Authorization in writing at any time prior to its termination, except to the extent that information has already been disclosed while this Authorization was in effect. I understand that any previously disclosed information would not be subject to the revocation request. I permit a copy of this authorization to be used in place of the original.

Expiration of Authorization: Unless otherwise revoked, this authorization will expire on the following date or event_____________________________. If I fail to specify an expiration date or event, this authorization will expire automatically one year from the date signed.

I have read and understand the terms of this Authorization and I hereby authorize the disclosure of my information in the manner described above. I release Chad P. Nevola, M.D., Inc., its employees, agents, officers, and medical staff members from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein. I represent that the signature below is my own and that I am legally authorized to sign this document.

____	______________________________
Signature of Patient or Legally Authorized Representative**	**Date**
____	______________________________
Printed Name of Patient or Legally Authorized Representative	**Relationship to Patient**

**This Authorization will only be valid if signed by the patient, the parent or guardian of the patient if he/she is a minor (unless the patient is age 12-17 and the authorization includes information from categories listed under special records), or the patient's legally authorized representative (e.g., power of attorney, health care proxy, etc.). If you are not the patient, please indicate your relationship to patient above and submit a copy of the applicable legal documentation if you are a legally authorized representative (if not already provided).

Chad P. Nevola, M.D., Inc.
120 Dudley Street, Suite 105
Providence, RI 02905
401-273-9555