Barrington Pediatric Associates, Inc.
334-D County Road
Barrington, RI 02806

401-247-2288 fax 401-247-2960

AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION

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

1. I hereby authorize Barrington Pediatric Associates, Inc. to:

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

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

_____
Street City State Zip

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: Barrington Pediatric Associates, Inc.
334D County Rd., Barrington, RI 02806

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

- **There is a $15 charge to release medical records, due at request.**

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