ROGER WILLIAMS UNIVERSITY
AUTHORIZATION FOR DISCLOSURE OF **MEDICAL** INFORMATION

By signing below, I authorize _____ (the "Authorized Discloser") to disclose my health information ("Information"). I understand that signing this Authorization is voluntary.

6 W X G H Q W 1 D P H _____ DOB: _____

Home Address: _____

Date of last semester attend L Q J RWU: _____

Information is to be sent to [Name and address]: _____

Information to be disclosed: & K H F N $ O O $ S S O L F D E O H

B B B B Entire Medical Record) H H R I I R U F R S \ R I P H G L F D O U H F R U G W R E
B B B B Lab Results R U D W R U \ W H V W V
B B B B Psychiatric notes
B B B B X-rays
B B B B Other (specify)

Are there date restrictions on the Information to be disclosed?

____ No ___ Yes (specify the timeframe of the records): _____

Purpose(s) of disclosure [Check one]:

___ Transfer medical care ____ Coordination of care with other medical provider
___ Other (specify): _____

The patient or the patient's legal representative agrees with the following statements:

- I understand that the Information disclosed may include information pertaining to the treatment of drug and alcohol abuse, mental health/illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis, hepatitis C or genetic tests. If you do not wish for this specific information to be disclosed, please describe the information to be excluded: _____
- I understand my treatment, payment, enrollment or eligibility for benefits will not be affected if this Authorization is not signed.
- I understand that this Authorization will expire in one (1) year, unless sooner revoked or otherwise particularly specified as follows: _____ years/months.
- I understand that I may revoke this Authorization at any time by notifying the Authorized Discloser in writing, but if I do, it will not have any effect on any actions taken before the Authorized Discloser received the revocation.
- I understand that there is potential that the recipient of the Information may re-disclose the Information and the Information may not be protected by federal or state privacy laws.

Signature of S D W L H Q W R U Legal Representative Date

3 U L Q W H G Q D P H R I Legal Representative _____

Description of authority to act for the patient