Family Health and Sports Medicine
65 Sockanosset Cross Road, Suite 301
Cranston, RI 02920
Phone: 401-943-6910 Fax: 401-946-5130

Request For Release of Records

Name:_____**Date of Birth:**_____

Address:_____

I hereby authorize Family Health and Sports Medicine to:

[ ] Release Information To: (Name)_____

[ ] Obtain Information From: (Name)_____

Address:_____

Records being requested

Labs: _____ **Stress Test/EKG:** _____

Radiology: _____ **Other:** _____

Hospital Visits:
Dates of Service/Duration of Stay: _____

I understand that my records are protected under federal confidentiality regulations for alcohol and drug abuse treatment (42 CFR, part) and/or the General Laws of the State of Rhode Island. I also understand that further disclosure of this information is not permitted without my express written authorization.

I have read carefully or have been read to and understand the above statements and voluntarily consent to disclose the above information and/or medical records to those persons/agencies named above. This information includes:
[ ] Drug and alcohol abuse treatment: Patient's Initials Authorizing Release _____
Patient or Legal Guardian's Initials

[ ] Mental health, HIV and AIDS Records: Patient's Initials Authorizing Release _____
Patient or Legal Guardian's Initials

I further release Drs. Rosenberg, Wilson, and Rubeor and their employees from any liability arising from the release of information to such persons/agencies provided and the said release of information is done substantially with applicable law.

I understand that I may revoke this content at any future time and that it will automatically expire 90 days after it is signed or after the above has been accomplished.

I understand that further disclosure of this information is not permitted without my express written consent.
Signature: _____**Date:** _____

Guardian/Responsible Party: _____ **Date:** _____

Relation to Patient: _____

Witness: _____ **Date:** _____

We ask that you fax all medical records to: 401-946-5130