Family Health and Sports Medicine
65 Sockanosset Cross Road Suite 301
Cranston, RI 02920
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 from: Name/Organization: ____

Address: ____

Records being requested

Labs: ____________________ Stress Test/EKG:__________________

Radiology: ___________________ Other: __________________________

Hospital visits:
Date of service _________________________ Duration of stay ____________________

We ask that records exceeding 10 pages be mailed to our office rather than be faxed. Thank you for your cooperation.

I understand that my records are protected under the federal confidentiality regulations of 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 name above. This includes alcohol/drug abuse records, mental health records and HIV (AIDS) results.

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

I understand that I may revoke this consent at any further time and that is will automatically expire 90 days after it is signed or after above have 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:________________