

## Rhode Island Authorization for the Use and Disclosure of Protected Health Information

Name:	Date of Birth:	SSN:	Date of Request:
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Address: \_\_\_\_\_

I authorize \_\_\_\_\_ [insert health care provider or entity] \_\_\_\_\_ to release my Protected Health Information (“PHI”), as specified below, to \_\_\_\_\_ [insert settlement provider] \_\_\_\_\_ (the “Provider”), \_\_\_\_\_ [insert address] \_\_\_\_\_.

**Specific information to be released:**

- Entire Medical Record including, but not limited to, patient histories, office notes, progress reports, physical exams, laboratory results, radiology and other diagnostic reports and images, operative reports, hospital records, referrals and consults, insurance records, records sent by other health care providers, and the specific medical records initialed below.

**I specifically authorize the release of my medical records to include the following records: (Initial)**

_____ Alcohol/Drug Abuse Information	_____ Genetic testing and/or DNA analysis
_____ Prescription Drug Information	_____ HIV/AIDS test results and treatment
_____ Sexually Transmitted Disease Information	_____ Mental Health Information (other than psychotherapy notes)

**The information will be obtained, used or disclosed for the following purposes:** To facilitate the settlement transaction as requested by the Insured/Patient or Authorized Representative and other related settlement business operations.

**I understand and agree to the following:**

- The signing of this authorization is voluntary. My treatment, payment or eligibility for benefits will not be conditioned upon my authorization of this disclosure. I may refuse to disclose all or some health care information, but such refusal may result in a denial of my application to enter into a settlement transaction regarding my life insurance policy(s).
- Once disclosed to the Provider, my PHI may be subject to redisclosure and may no longer be protected by HIPAA. My PHI may be further disclosed to the insurance company that issued my life insurance policy and the following potential and subsequent purchasers, financing entities, and other independent third parties for purposes of facilitating my requested settlement transaction, resale of my life settlement and other related settlement business operations: \_\_\_\_\_ [insert names of entities] \_\_\_\_\_ (collectively, “Authorized Recipients”). **By signing below, I authorize the disclosure of my PHI to the Authorized Recipients for the purposes specified in this authorization form.**
- Information disclosed, released, or transferred will not be given, sold, transferred, or in any way relayed to any party not specified in this authorization form.
- The information authorized for release may include alcohol or drug abuse treatment records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. **By initialing above and signing below, I specifically authorize the disclosure of alcohol and drug abuse treatment records to the Authorized Recipients for the purposes specified in this authorization form.**
- State law requires that I specifically authorize any disclosure of HIV-related, sexually transmitted disease, or mental health information. **By initialing above and signing below, I specifically authorize the disclosure of my HIV-related, sexually transmitted disease, and mental health information for the purposes specified in this authorization form.**
- This authorization may be revoked at any time by notifying the Provider of my revocation in writing. However, my revocation will not apply to information already retained, used or disclosed prior to receiving the written revocation notice. Unless revoked, this authorization will expire upon my death.

Signature of Insured/Patient, or Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by someone other than the Insured/Patient, state your authority to act for the individual: \_\_\_\_\_

Witness: *(required to obtain drug and alcohol abuse records)*

Date: \_\_\_\_\_

USAGE NOTES:

1. This Authorization for the Use and Disclosure of Protected Health Information has not been approved for use in any jurisdiction. Please check with your state's insurance department before using this form.
2. ILMA makes no representation or warranty regarding this form or its compliance with laws. Accordingly, you should consult your counsel before using this Authorization for the Use and Disclosure of Protected Health Information in order to ensure that it complies with applicable law and regulations.
3. Please note that additional or different PHI forms may be needed in the event that the Insured resides in a different state. Any additional forms required should be attached hereto as Annex A.

## ANNEX A

### ADDITIONAL DISCLOSURES

**[Drafting Note: This Annex will contain additional Protected Health Information forms or provisions, required by the state in which the Insured resides. In some cases, a form tailored to the specific requirements of the state where the Insured resides will be substituted for the form to which this Annex A is attached. ]**