Record Release Form
3 Capitol Hill Providence RI 02908
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ **D.O.B:** / /

Previous Name: _____ **Hospital of birth:** _____

Mother's Name at Patient's Time of Birth: _____

Patient's current phone number _____ **Patient's current email address**_____

I request and authorize the Newborn Screening Program to release newborn screening results for the patient named above to the following **Healthcare provider or Public Health agency**:

Attention: _____
Name: _____
Street Address: _____
City, ST Zip Code _____

This request and authorization applies to the following information:
Newborn Screening Results

This information is to be:

Mailed to address above _____ Faxed to:_____
Fax Number

Emailed via secure email to:_____

This authorization and/or request to release this information is fully understood and is made voluntarily on my part and may include faxing of medical record information. I understand that this disclosure may include sensitive information; and that this consent is subject to revocation at any time except to the extent that action passed on this consent had already been taken. I understand that a photo scan or faxed copy of the consent is as valid as the original.

_____ _____
Patient Signature **Date**

_____ _____
Witness Signature **Date**