REQUEST FOR DISCLOSURE REPORT FORM

RHODE ISLAND HIE

Directions for completing this form

1. **Print and complete the request form**
   If you cannot print the form, call 866-957-4254 and request that it be mailed to you

2. **Sign, date, and obtain authorization via a notary public**

3. **Mail the form to us at: PO Box 1152, Columbia, MD 21044-9997**

Note: *If you are someone who makes healthcare decisions for this patient and are requesting an accounting of disclosures, you must verify by attaching a copy of the court order of legal guardianship or Durable Power of Attorney.*

1. **Request for Accounting of Disclosures Report.** I authorize CRISP Shared Services (CSS) to prepare an Accounting of Disclosures Report outlining all disclosures of my health information to users of Rhode Island HIE during the period specified. I understand that the period of disclosures reported as a result of this request will not exceed the past six years.

2. **Effective Date of Request.** This request will become effective when it is received by CSS and confirmed to be complete. I understand that CSS will make every effort to produce the requested report as soon as possible and no later than 60 days of a completed request or to make me aware of any cause for delay in my request. CSS may also request a 30-day extension to produce the report. I understand that CSS will review the effective date of this request and, if it has been less than 12 months since the last request for a report of disclosures of my health information, CSS may require reasonable payment for this report.

3. **Effect of Request.** As a result of this request, CSS will provide an Accounting of Disclosures Report to the enrollee named or their authorized representative or agent. I hold CSS harmless for any subsequent disclosure of this report once it is released to the requestor.

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RHODE ISLAND HIE

Rhode Island HIE Patient Information

Patient Name *(Please Print or Type)* *Last* *First* *Middle Initial*

Address:

City: **State:** **Zip:**

Phone: ( ) **Email Address:**

I am requesting a disclosure report for these dates: **to**

Please provide my report in this format: ☐ Electronic ☐ Paper **Delivery by:** ☐ Mail to the address above ☐ Secure email

If you are the patient:

I affirm that the information contained on this form is true and accurate.

Print Name clearly:

Signature: **Date:**

If you are *not* the patient:

Please indicate your relationship to the patient: ☐ A parent* ☐ Legal guardian* ☐ Power of Attorney

Your Name:

Address: **City:** **State:** **Zip:**

Phone: **Email Address:**

****Note: Restrictions apply to disclosure of certain information related to minors***

I affirm that the information contained on this form is true and accurate.

Print Name clearly:

Signature: **Date:**

Authentication:

My commission expires:

Signature: **Date:**

For CSS Use only: Verification was obtained by: ☐ Verified two forms of ID ☐ POA ☐ Notary Public

Verified by CSS Representative: