TOWN OF WESTERLY • POLICE DEPARTMENT
60 Airport Road, Westerly, Rhode Island 02891 • 401-596-2022 FAX 401-596-7501

APPLICATION INSTRUCTIONS FOR A LICENSE TO CARRY A CONCEALED FIREARM

NO APPLICATIONS WILL BE CONSIDERED UNLESS THESE INSTRUCTIONS HAVE BEEN PROPERLY FOLLOWED:

1. This official application form must be filled out completely by the applicant. Please print legibly, or preferably, type the application form.

2. Proof of qualification by a certified weapons instructor, i.e.: an NRA or police range instructor, along with a copy of the NRA/FBI firearms instructor's certification (including expiration date). The applicant must have qualified within six (6) months from the date of application.

3. Three (3) references and reference letters are required for **NEW** applications and are to be submitted along with the application. All three references are to type (not handwritten) a letter for the applicant pertaining to the gun permit that is signed, dated and **MUST** be notarized. Reference letters must be written by the reference, not the applicant and cannot be identical.

4. Renewal applications require the references **ONLY** and do not require reference letters.

5. If the license is to be solely for employment purposes, a typed letter of explanation why the applicant is a suitable person to be licensed must be submitted by the applicant's employer on the employer's letterhead and attached to the application.

6. If the license is not solely for employment purposes, a typed letter must be submitted by the applicant stating the reason(s) why a license is needed on a full-time basis. Included in this letter must be an explanation why the applicant is a suitable person to be licensed and how the applicant plans to properly secure the firearm, so that it does not fall into unauthorized hands. All letters must be dated. The Town will not accept photocopies of any signatures.

7. The permit processing fee is forty dollars ($40.00) and must be paid by check or money order to the Town of Westerly when the application is submitted.

8. New applicants are required to be fingerprinted and complete an FBI fingerprint card (FD-258 Rev. 12-29-82). The fingerprinting service costs forty-six dollars ($46.00), payable by check or money order to the Town of Westerly at the time of fingerprinting. This fee is separate from the forty-dollar ($40.00) permit processing fee. Renewal applications will **NOT** require fingerprints.

9. Pictures will be taken of the applicant at the police station, when submitting a **NEW** application, or a **RENEWAL** application.

10. The applicant must sign waivers for the release of criminal and medical records, including mental health treatment facilities to determine whether an applicant has been treated for any past, or current mental health issues.

11. Two (2) photocopies of positive identification must be submitted. Both photocopies must be signed and dated by a notary public attesting to be true copies. A digital photograph will be taken by police personnel after the application has been approved.

12. All new applicants shall be interviewed by a panel selected by the Chief of Police.

13. If the application is approved, the applicant will be notified to appear in person at the police department. If the applicant is denied, he or she will be notified of the reason for the denial. The application becomes part of the application process and will not be returned.

14. All **permits will expire four (4) years from the date of issuance**. Renewal of the application is the applicant's obligation. **No** notification of the expiration of the permit will be sent to the applicant. Applicants must allow a minimum of ninety **(90)** days to process an application.

15. Retired police officers applying under Rhode Island General Law §11-47-18 must submit a letter of verification from the Chief of Police of the police department from which they served stating that they have completed twenty (20) years in good standing.

16. All **NON-RESIDENT** applicants must include a copy of their home state concealed weapon permit.

17. Falsifying, misleading, erroneous information or omitting any pertinent information may lead to a denial of the application.

18. Any arrest, which would include an appearance in criminal proceedings before the District, Superior, Supreme or U.S. Federal Court must be listed on the application. This requirement does not include traffic summonses but does include charges of operating a motor vehicle on a suspended or revoked license or operating without a license.

19. All the above instructions must be properly followed, or the Town will not process the application.

Westerly Police Department

60 Airport Road
Westerly, RI 02891

Phone – (401) 596-2022
Fax – (401) 596-7501

Paul J. Gingerella
Chief of Police

APPLICATION FOR A LICENSE TO CARRY A CONCEALED WEAPON PURSUANT TO RHODE ISLAND GENERAL LAW §11-47-11

NAME: _____
First Middle Last

ADDRESS: _____
Street Address (No P.O. Boxes) City/Town State/Zip

TELEPHONE NUMBER: _____
Home ☐ Business ☐ Other ☐

SOCIAL SECURITY NUMBER:_____ OCCUPATION: _____

EMPLOYED BY: _____

_____
Employer's Address Street Name and Number City/Town State/Zip

_____
Employer's Address Street Name and Number City/Town State/Zip

DETAILED JOB DESCRIPTION(S): _____

_____

_____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ EYE COLOR: _____ HAIR COLOR: _____

ARE YOU A CITIZEN OF THE UNITED STATES? YES ☐ NO ☐

(If you are not a citizen of the United States, a copy of both sides of your lien registration card must be included with this application).

LIST ALL ADDRESSES FOR THE LAST THREE YEARS, INCLUDING DATES OF RESIDENCE:

DATES ADDRESS

_____TO_____ _____

_____TO_____ _____

_____TO_____ _____

HAVE YOU EVER BEEN ARRESTED? **YES**☐ **NO**☐ IF YES, PROVIDE DETAILS:

_____

_____

_____

HAVE YOU EVER BEEN CONVICTED OF A CRIME? **YES**☐ **NO**☐ IF YES, PROVIDE DETAILS:

_____

_____

_____

HAVE YOU PLED GUILTY OR NOLO CONTENDERE TO ANY CRIMINAL CHARGE OR VIOLATION?
YES☐ **NO**☐ IF YES, PROVIDE DETAILS:

_____

_____

_____

ARE YOU CURRENTLY UNDER INDICTMENT FOR A CRIME PUNISHABLE BY IMPRISONMENT EXCEEDING ONE YEAR? **YES**☐ **NO**☐ IF YES, PROVIDE DETAILS:

_____

_____

_____

HAVE YOU EVER BEEN THE SUBJECT OF OR BEEN ISSUED A PROTECTIVE COURT ORDER? **YES**_☐_ **NO**_☐_ IF YES, PROVIDE DETAILS:

_____

_____

_____

HAVE YOU EVER BEEN UNDER GUARDIANSHIP, CONFINED OR TREATED FOR A MENTAL ILLNESS? **YES**_☐_ **NO**_☐ IF YES, PROVIDE DETAILS:

_____

_____

_____

HAVE YOU APPLIED FOR A PERMIT TO CARRY A CONCEALED PISTOL OR REVOLVER FROM THE RHODE ISLAND DEPARTMENT OF ATTORNEY GENERAL OR A LOCAL CITY OR TOWN IN RHODE ISLAND? **YES**_☐_ **NO**_☐_

IF YES, NAME THE AGENCY OR CITY/TOWN WHERE APPLICATION WAS FILED:

_____

IF YES, IS IT CURRENTLY:

ACTIVE__☐___EXPIRED__☐___ DENIED__☐___ REVOKED__☐_____

(If you hold an expired permit enclose a photocopy, notary signed and dated, attesting that the copies are true).

HAVE YOU EVER APPLIED FOR A PERMIT TO CARRY A CONCEALED WEAPON IN ANOTHER STATE? **YES**_☐_ **NO**_☐_ IF YES, NAME OF STATE AND CITY OR TOWN WHERE THE APPLICATION WAS FILED:

_____

WAS YOUR OUT-OF-STATE APPLICATION DENIED? **YES**_☐_ **NO**_☐_ IF YES, PLEASE PROVIDE DETAILS:

_____

_____

IF YOU POSSESS AN OUT-OF-STATE PERMIT, KINDLY ATTACH A COPY TO THIS APPLICATION.

HAVE YOU EVER HAD YOUR NAME LEGALLY CHANGED? **YES**☐ **NO**☑

IF YES, PLEASE STATE YOUR FORMER NAME:_____

LIST THE NAMES OF THREE (3) REFERENCE WHO MUST SUBMIT LETTERS OF REFERENCE SUPPORTING YOUR APPLICATION.

_____

Name Address City/State/Zip

_____

Telephone number Years Known

_____

Name Address City/State/Zip

_____

Telephone number Years Known

_____

Name Address City/State/Zip

_____

Telephone number Years Known

PLEASE LIST ALL NICKNAMES OR ALIASES

_____

_____

TWO (2) TYPES OF POSITIVE IDENTIFICATION MUST BE SUBMITTED WITH THIS APPLICATION. THEY MUST BE PHOTOCOPIED, SIGNED AND DATED BY A NOTARY PUBLIC ATTESTING TO BE TRUE COPIES. EXAMPLES OF POSITIVE IDTENTIFACTION INCLUDE: BIRTH CERTIFICATE, RHODE ISLAND OR STATE OPERATOR'S LICENSE, RHODE ISLAND IDENTIFICATION CARD, PASSPORT, OR OTHER AUTHENTIC FORMS OF POSITIVE IDENTIFCATION.

ON A SEPARATE SHEET OF PAPER OR LETTERHEAD, TYPE DETAILS AND SPECIFIC REASONS WHY YOU HAVE A GOOD REASON TO FEAR AN INJURY TO YOUR PERSON OR PROPERTY OR ANY OTHER PROPER REASON TO CARRY A PISTOL OR REVOLVER AND WHY YOU ARE A SUITABLE PERSON TO BE SO LICENSED.

_____ _____

Signature of Chief of Police Date

Approved☐_____ *Disapproved*☐_____

THE RI COMBAT COURSE IS FOR LAW ENFORCEMENT PERSONNEL ONLY
ALL OTHERS MUST QUALIFY IN ACCORDANCE WITH RHODE ISLAND GENERAL LAW §11-47-15

WEAPON QUALIFICATION SCORE:_____ CALIBER OF WEAPON:_____

ARMY-L SCORE:_____ R.I. COMBAT SCORE:_____

_____
SIGNATURE OF NRA INSTRUCTOR OR POLICE RANGE OFFICER

_____
PRINTED NAME & TELEPHONE NO. OF NRA INSTRUCTOR OR POLICE RANGE OFFICER

_____
NRA NUMBER OR POLICE DEPARTMENT NAME DATE OF QUALIFICATION

AFFIDAVIT

I CERTIFY THAT I HAVE READ AND AM FAMILIAR WITH THE PROVISIONS OF 11-47-1 THROUGH 11-47-62, INCLUSIVE, OF THE GENERAL LAWS OF RHODE ISLAND, 1956, AS AMENDED, AS WELL AS ALL FEDERAL STATUES PERTAINING TO FIREWARMS AND THAT I AM AWARE OF THE PENALTIES FOR VIOLATIONS OF THE PROVISIONS OF THE CITED SECTIONS. I FURTHER UNDERSTAND THAT ANY ALTERATION OF THIS PERMIT IS JUST CAUSE FOR REVOCATION.

_____ _____
Applicant's Signature Date

NOTARY PUBLIC

Subscribed and sworn to before me in the Town of Westerly, County of Washington, State of Rhode Island on the _____ day of , 20_____

_____ _____
Notary Public Signature Notary Public (Name Printed)

My commission expires on: _____

Westerly Police Department

AUTHORIZATION FOR RELEASE OF INFORMATION

Concealed Weapon Permit

I, , have made an application for a concealed weapon permit with the Town of Westerly, and it is my understanding that a comprehensive investigation of my background will be conducted in connection with my application. I understand that any history, which adversely reflects on my qualifications for a concealed weapon permit, may cause for disqualification from further consideration to receive a concealed weapon permit.

I hereby give the Town of Westerly and its agents, the authority to conduct a comprehensive investigation of my background including, but not limited to, oral interviews with any person concerning my background and a review with full disclosure of all records and other information, whether such records and other information are public, private, privileged or confidential. This review includes records maintained by past and present employers, law enforcement agencies, public utility companies and other local, state and federal agencies. This **Authorization for Release of Information; Concealed Weapon Permit form** is solely for the purpose of conducting an applicant background investigation for a concealed weapon permit.

To the custodian of records discussed herein, I hereby authorize you to release information to the bearer of the **Authorization for Release of Information; Concealed Weapon Permit** form. I consider a copy of the **Authorization for Release of Information; Concealed Weapon Permit** form to be as valid as the original, even though a copy does not have my original signature.

I hereby release to the Town of Westerly and its agents and anyone who gives written or oral information about me to the Town of Westerly from any claims of liability or damages, which may occur as a result of the background investigation. This release also extends to my heirs, associates, assigns and representatives.

_____ _____

Date Signature of Applicant

_____

Social Security Number

_____

Driver's License Number

_____

Date of Birth

INSTRUCTIONS FOR COMPLETING THE BHDDH AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION FORM

Please write legibly, in ink

Section 1. Print the name and date of birth of the individual whose information is to be released.

Section 2. Check all of the boxes that apply: Write-in information where indicated (e.g., Physical, Occupational, Respiratory)

Section 3. Check the box(s) next to the type(s) of sensitive information if you do not want this sensitive information to be released.

Section 4. Print the name and address of the organization authorized to release the information, and the name and telephone number of the contact person from the organization that will be releasing the information.

Section 5. Print the name and address of the organization authorized to receive the information, and the name and telephone number of the contact person from the organization that will be receiving the information.

Section 6. Indicate the specific month and year that reflect the beginning and ending dates of service associated with the information being released. Please do not use an unspecific description such as "All Dates of Service".

Section 7. Indicate the reason why the information is needed.

Section 8. Print the name and address of the individual at MHRH responsible for receiving an individual's instructions to revoke the authorization.

Section 9. Dated signature of the individual whose information is to be released.

Section 10. Signature and printed name of the authorized representative with a description of their relationship to the individual whose information is to be released.

Note: An authorized representative is required only if the individual whose information is to be released is incapable of authorizing the release of confidential information.

FULLER HOSPITAL

LEADING THE WAY IN BEHAVIORAL HEALTH

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____
Maiden/Prior Names: _____ Current Phone #: _____
Current Address: _____ Last 4 of SS#: _____

To be released to or requested from:

☐ Self (address above)

☑ Westerly Police Dept. (401) 596-2022 60 Airport Rd.
Agency/Organization Telephone Number Street Address

Detective Hayden (401) 348-4641 Westerly RI 02891
Name / Attention to Fax Number City State Zip Code

Via (only when released to): ☐ Mail ☐ Fax ☐ Pick-up ☑ Email: mhayden@westerlypolice.org
☐ Verbal Exchange of Information ONLY

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use
☐ Academic ☐ Legal Investigation ☐ Billing/Insurance ☑ Other: Pistol permit

Dates of Service Requested: 1990-Present

☑ **I authorize the release of the following information <u>including</u> all records that include any substance use disorder and/or substance use disorder treatment records, or**

☐ **I authorize the release of the following information <u>excluding</u> all records that include any substance use disorder and/or substance use disorder treatment records,**

Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

☐ Continuity/Transition of Care Packet
☑ Psychiatric Evaluation
☑ History and Physical
☐ Discharge Summary
☐ Progress Notes
☑ Physician Orders
☐ Lab/Diagnostic Reports
☐ HIV Test Results and AIDS Treatment Records
☐ Other: _____

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire <u>one year</u> from signature date)

This form must be completed in full before signing:

_____ _____ _____
Patient's signature (required for ages 18 and older) Parent/Legal Guardian signature (if applicable) Relationship to Patient

_____ _____
Witness signature/Credentials Date Signed

This authorization is intended to allow Fuller Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request. _____ _____
Revocation Signature Date/Time

10136

Care New England

FOR INPATIENTS: AFFIX PATIENT LABEL OR
WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME AND DOB

PATIENT NAME: _____

DOB OR MR #: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

10136 (5-2021)

1. Patient Name: _____("Patient") Date of Birth: _____ Telephone: _____

   Address _____Med. Rec #: _____
   Street City State Zip

2. This undersigned herby Authorizes the following CNE Provider ___Butler Hospital_____

   Address 345 Blackstone Boulevard, Providence, RI 02906
   Street City State Zip

   Telephone: _____ Fax: _____

   ☑ to release/disclose to the individual and/or entity named in Section 3 ("Recipient")
   AND/OR
   ☑ to request/receive from the individual and/or entity named in section 3 ("Disclosing Party")
   the protected health information ("Health Information") specified in Section 4

3. Recipient or Disclosing Party: Westerly Police Department (Insert Individual/Entity Name)

   Telephone: 401-596-2022 Fax Number (if Health Information is to be faxed): 401-348-4641

   Address 60 Airport Rd. Westerly, RI 02891
   Street City State Zip

4. Please check one or more types of Health Information to be released/requested:

_____Allergies	_____Laboratory Results	_____Operative Report
_____Immunization Records	_____X-Ray/Imaging Results	_____Psychiatric Exam
_____Emergency Dept. Records**	_____History & Physical	_____Psychological Tests
_____Registration Record	_____Progress Notes	_____Treatment Plan(s)
_____Discharge Summary	_____Consultation Reports	_____Entire Record

   OTHER (Please Specify): Mental Heatlh Information
   **An authorization for Emergency Department Records may include any of the above listed Health Information Records.

5. Time Frame for which the Health Information authorized in Section 4 above should be released/requested:
   For the period from _____ (insert start date) through _____ (insert end date);
   OR ALL DATES OF TREATMENT _____ (Please initial)

6. The undersigned acknowledges, agrees, and understands that unless specifically limited below, any Health Information released may include mental health treatment information, alcohol abuse treatment information, STDs and/or HIV/AIDs related information.
   DO NOT RELEASE THE FOLLOWING HEALTH INFORMATION (please specify):_____

7. This authorization is being requested by the undersigned for the following purpose(s) (initial all that apply)
   _____ Medical Care _____ Legal _____ Insurance _____ Personal
   Other (Please Describe): Conceal Carry Pistol Permit

8. The undersigned acknowledges and understands each of the following:
   - Authorizing the release of the Patient's Health Information is voluntary;
   - Refusal to sign this authorization does not affect the Patent's treatment, payment of claims, health plan enrollment or eligibility for benefits;
   - This authorization may be revoked at any time upon written request to the Provider's privacy officer or health information department except to the extent that release of Patient's Health information has already occurred in reliance on this authorization;
   - Unless previously revoked, this authorization will automatically expire TWELVE (12) months from the date of signature below unless a shorter timeframe specified here _____ (enter date authorization will expire);
   - Any information released to Recipient may be re-disclosed and may no longer be protected by federal or state privacy and or confidentiality laws.

THE UDNERSIGED (1) HAS READ AND UNDERSTANDS THIS AUTHORIZATION;(2) HAS HAD ANY QUESTIONS WITH RESPECT TO THIS AUTHORIZATION EPXLAINED TO HIS/HER SATISFACTION; (3) IS AUTHROIZED TO SIGNED THIS AUTHORIZATION INDIVIDUALLY AS THE PATIENT OR AS THE PATIENT'S LEGAL REPRESENTATIVE; AND (4) HEREBY EXPRESSLY AND VOLUNTARILY AUTHORIZES THE RELEASE/REQUEST OF THE PATIENT'S HEALTH INFROMATION AS SPECIFIED ABOVE.

_____ _____
Signature of Patient or Legal Representative Patient Date/Time

_____ _____
PRINT Name of Patient or Legal Representative Patient Relationship to Patient or Authority to Act for Patient

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILTIES AND HOSPITALS

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

1. I, _____
(Print first name, last name & date of birth of the Individual for whom information is being requested)

2. I hereby authorize the following information to be released: (check all that apply)

☑ Physician Orders	☑ Social Service Records	☑ Continuity of Care Forms	☑ Therapy Reports
☑ Physician Progress Notes	☑ Laboratory Reports	☑ Inter-Agency Referral(s)	☐ Financial Records
☑ Discharge Summary	☑ History & Physical	☑ School/Edu. Records	☐ Billing Requests/Reports
☑ Nurses' Notes	☑ Consultation Reports	☑ Psychology Records	☐ Vocational Records

☑ Other (please be specific) Mental Health, Alcohol and Drug Treatment

3. I hereby authorize the following information to be released*: (check all that apply)

☑ Substance Abuse/dependency/diagnosis/treatment/referral (42 CFR) ☑ Mental Health/diagnosis/treatment/referral
☐ HIV Test results /AIDS related information/(ARC) diagnosis and/or treatment
☐ Diagnoses and/or treatment relating to other communicable diseases

* This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

4. My information is to be obtained from:

Eleanor Slater Hospital
(Name of Organization)
111 Howard Ave.
(Address)
Cranston, RI. 02920
(City/State/Zip)
_____
(Contact Name and Telephone Number)

5. My information is to be released to:

Westerly Police Department
(Name of Organization)
60 Airport Road
(Address)
Westerly, RI 02891
(City/State/Zip)
_____
(Contact Name and Telephone Number)

6. This authorization is for information applicable to the time period specified below:

From: 1990 To: Present

7. Subject is applying for a license to carry a conceeal firearm.
(Indicate the specific purpose or need for this release of information)

8. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the federal privacy regulations. BHDDH may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization. I understand that I have the right to revoke this authorization in writing at anytime, and that the revocation will be effective except to the extent that the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) has already taken action in reliance on my authorization. I understand that if this authorization has not been revoked, it will expire in six months from the date of my signature. **My instructions to revoke my authorization should be directed to:**

_____
(Name and address of BHDDH Records person responsible for this request)

9. Signature of individual: _____ Date: _____

10. Signature of authorized representative _____ Relationship: _____

Print Name: _____ Date: _____

For Office Use Only: Information Released: Y N Date of release: _____
Staff Person Releasing Information: _____

McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Health Information Management
121 Inner Belt Road, Room 240, Somerville, MA 02143
Telephone 617.726.2361 Fax 617.726.3661

3-Hole 5/16 4 1/4 c-to-c

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

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

Specific information to be released:
- ☑ Verbal Information/Telephone Update
- ☑ Discharge/Treatment Summary
- ☑ Other *(specify)* Mental Health

Purpose:
- ☑ Treatment
- ☐ Financial
- ☐ *Personal
- ☑ *Other Suject is applying for a license to carry a conceal firearm

☐ I hereby authorize the **following person or facility to release** the above information to McLean Hospital:

☑ I hereby authorize **McLean Hospital to release** the above information to the following person or facility:

To: ☐ Referring/Aftercare Clinician ☐ PCP ☐ Other

Name/Facility: Westerly Police Department

Address: 60 Airport Road Westerly, RI 02891

mhayden@westerlypolice.org

Specific information to be released:
- ☐ Verbal Information/Telephone Update
- ☐ Discharge/Treatment Summary
- ☐ Other *(specify)* _____

Purpose:
- ☐ Treatment
- ☐ Financial
- ☐ *Personal
- ☐ *Other _____

☐ I hereby authorize the **following person or facility to release** the above information to McLean Hospital:

☐ I hereby authorize **McLean Hospital to release** the above information to the following person or facility:

To: ☐ Referring/Aftercare Clinician ☐ PCP ☐ Other

Name/Facility: _____

Address: _____

**Copying fees may apply*

Information should be sent to: McLean Hospital, 115 Mill Street, Belmont, MA 02478-9106

Attention: (*Name of McLean staff member who should receive the information)* _____

Mental Health Information. I authorize disclosure of such information, including details of mental health diagnosis and/or treatment provided by a Psychiatrist, Psychologist, Licensed Mental Health Clinician, Advanced Practice Nurse, or Licensed Social Worker.

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management. Authorization may be withdrawn except to the extent that action has already been taken in reliance on this authorization. If the authorization was obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy, even if authorization has been withdrawn.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by McLean Hospital.
- This release will expire 180 days from the date below or as otherwise specified: _____.

YES *Please check yes for the following questions, to indicate if we may release information below (if it is in your medical record.)*

- ☑ **Alcohol and Drug Abuse Treatment.** To the extent that my medical record contains information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2.
- ☐ **HIV Information.** To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by M.G.L. Ch.111 §70f.
- ☑ Details of Domestic Violence Victims' Counseling
- ☐ Details of Sexual Assault Counseling

Patient or Patient Representative: Please make sure that all appropriate sections above are completed before signing this authorization. Do *not* sign a blank authorization form.

_____ _____ _____

Signature of Patient (if 18 or older); *or* Parent (if patient is under 18); *or* Legal Guardian; or Health Care Agent *(circle one)*

Printed Name of Patient or Authorized Person

Date

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT INFORMATION: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VHA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA" and in accordance with the VHA Notice of Privacy Practices. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Westerly Police Department
60 Airport Road Westerly, RI 02891

VETERAN'S REQUEST

I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

- [X] DRUG ABUSE
- [ ] SICKLE CELL ANEMIA
- [X] ALCOHOLISM OR ALCOHOL ABUSE
- [ ] HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

DESCRIPTION OF INFORMATION REQUESTED

Check applicable box(es) and state the extent or nature of information to be provided:

- [X] HEALTH SUMMARY *(Prior 2 Years)*
- [ ] INPATIENT DISCHARGE SUMMARY *(Dates)*: _____
- [ ] PROGRESS NOTES:
  - [ ] SPECIFIC CLINICS *(Name & Date Range)*: _____
  - [ ] SPECIFIC PROVIDERS *(Name & Date Range)*: _____
  - [ ] DATE RANGE: _____
- [ ] OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____
- [ ] LAB RESULTS:
  - [ ] SPECIFIC TESTS *(Name & Date)*: _____
  - [ ] DATE RANGE: _____
- [ ] RADIOLOGY REPORTS *(Name & Date)*: _____
- [ ] LIST OF ACTIVE MEDICATIONS _____
- [X] OTHER *(Describe)*: Copy of outpatient Treatment Note(s)

PURPOSE(S) OR NEED

Information is to be used by the individual for:

- [ ] TREATMENT
- [ ] BENEFITS
- [ ] LEGAL
- [X] OTHER *(Specify below)*

Subject is applying for a license to carry a concealed firearm

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

AUTHORIZATION

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION

Without my express revocation, the authorization will automatically expire.

☐ UPON SATISFACTION OF THE NEED FOR DISCLOSURE

☐ ON _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED	RELEASED BY:

HEALTH INFORMATION SERVICES
AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED INFORMATION

☑ **REQUEST COPIES OF MEDICAL RECORD** _____ **REVIEW MEDICAL RECORD**

I do hereby authorize the following CharterCARE Health Partners affiliates entities (to include without limitation)

- ☑ Roger Williams Medical Center
- ☑ Our Lady of Fatima
- ☑ Southern New England Rehabilitation Center
- ☑ St. Joseph Health
- ☑

to release my protected health information, including copies of my medical record of care to the following person(s) or persons at the location/facility listed below for the purpose(s) as indicated:

Patient Name: _____ DOB: _____
(Last) (First) (M.I.)

Patient Address: _____
_____
_____

Patient Telephone (for contact): ( ) _____ work /home / cell

Email address: _____

Recipient

Westerly Police Department
Name
60 Airport Rd
mhayden@westerlypolice.org
Address
Westerly RI 02891
City, State, Zip Code

Purpose (*check the appropriate box*)

- ☐ Medical Care
- ☐ Legal Matter
- ☐ Insurance
- ☐ Personal
- ☑ Other (please specify) *

* Pistol Permit

Concerning my treatment for the period of: 1990-Present

PROTECTED HEALTH INFORMATION TO BE RELEASED *(Please check the appropriate box(s) and provide dates):*

- ☐ Discharge Summary (dates) _____
- ☐ Operative Reports (dates) _____
- ☐ Outpatient Test Results (dates) _____
- ☐ X-Rays/Scan Reports (dates) _____
- ☐ Pathology Reports (dates) _____
- ☐ Emergency Room (dates) _____
- ☐ Lab Reports (dates) _____
- ☐ Other *(please specify)* _____

☐ Reports ☐ Films ☐ Billing _____

☑ Medical Record Abstract (*e.g. Discharge Summary, Consultations, History & Physical, Operative, Pathology, and Test Reports)*

ROI

Authorization for Release of
Specifically Protected Information

I request the release of the specific categories of information that I have *INITIALED* below:

_____ HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATE(S): _____
_____Records pertaining to Sexually-Transmitted Diseases
_____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2
(FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

_____ Other(s): Please List _____

Confidential Details of:
_____ Psychotherapy (from a Psychiatrist, Psychologist, or Psychiatric Clinical Nurse Specialist)
(cannot be authorized in conjunction with non psychotherapy authorization)
_____ Other professional services of a licensed psychologist
_____ Social Work Counseling/Therapy
_____ Domestic Violence Victims' Counseling
_____ Sexual Assault Counseling

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management.
- Authorization may be withdrawn except for the following:
  *To the extent that action has been taken in reliance on this statement
  *If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization.
- If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and no longer protected by this rule.
- I understand that even if I do not withdraw this consent that this statement shall expire in:
  (please check one):_____3 months _____6 months_X__12 months _____Other
  (if no time is indicated authorization will expire in one year)

I have carefully read and understand the above, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____Date:_____ Relationship, if not patient_____

Print Name: _____Witness:_____Date:_____

_____
Basis of Authority to act on behalf of the patient

TO BE COMPLETED BY OFFICE STAFF/FACILITY RELEASING INFORMATION:

Date___/___/____ ID Verified: Y / N # Pages (if) Given to Patient_____ Initials: _____

Type of Delivery: Email _____ Mail _____ Other_____

ROI

TOWN OF WESTERLY • POLICE DEPARTMENT

60 Airport Rd, Westerly, Rhode Island 02891
401-596-2022 FAX 401-348-4641

Mental Health

Authorization for Release of Information

I, _____, do hereby authorize a review and full disclosure of all records, or any part thereof, concerning myself, by and to duly authorized agents of the Westerly Police Department, whether the said records are of a public, private, or confidential nature.

The intent of this authorization is to give my consent for full and complete disclosure of the records from **HIGHPOINT TREATMENT CENTER** regarding medical and psychiatric treatment and consultation, including records of hospitals, clinics and private practitioners operating within or in association with said **HIGHPOINT TREATMENT CENTER.**
I reiterate and emphasize that the intent of this authorization is to provide full and free access to the background and history of my personal life, for the specific purpose of pursuing a background investigation, which may provide pertinent data and/or information for the Westerly Police Department to consider in determining my suitability for issuance of a license to carry a concealed firearm.

It is my specific intent to provide access to personal information, however personal or confidential it may appear to be, and the sources of information specifically enumerated above is not intended to deny access to any records not specifically identified herein.

I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly, in whole or in part, pursuant to this release authorization will be considered in determining my suitability for issuance of a license to carry a concealed firearm by the Westerly Police Department. I have had explained to me, and I fully understand, that refusal to grant this authorization will not, of itself, constitute a basis for rejection of my application.

To the custodian of the records discussed herein, I hereby authorize you to release information to the bearer of this *Authorization for Release of Information.* I consider a copy of the *Authorization for Release of Information* to be as valid as the original even though a copy does not have my original signature.

I hereby release to the Westerly Police Department and its agents and anyone who gives written or oral information about me *to* the Westerly Police Department from any claims of liability or damages which may occur as a result of the background investigation. This release of liability also extends to my heirs, executors, assigns and representatives.

Print Name: _____ Date of Birth: _____

Signature: _____ Soc. Sec. #:_____

Address: _____

TOWN OF WESTERLY • POLICE DEPARTMENT

60 Airport Rd, Westerly, Rhode Island 02891
401-596-2022 FAX 401-348-4641

Mental Health

Authorization for Release of Information

I, _____, do hereby authorize a review and full disclosure of all records, or any part thereof, concerning myself, by and to duly authorized agents of the Westerly Police Department, whether the said records are of a public, private, or confidential nature.

The intent of this authorization is to give my consent for full and complete disclosure of the records from **STONINGTON INSTITUTE** regarding medical and psychiatric treatment and consultation, including records of hospitals, clinics and private practitioners operating within or in association with said **STONINGTON INSTITUTE.**

I reiterate and emphasize that the intent of this authorization is to provide full and free access to the background and history of my personal life, for the specific purpose of pursuing a background investigation, which may provide pertinent data and/or information for the Westerly Police Department to consider in determining my suitability for issuance of a license to carry a concealed firearm.

It is my specific intent to provide access to personal information, however personal or confidential it may appear to be, and the sources of information specifically enumerated above is not intended to deny access to any records not specifically identified herein.

I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly, in whole or in part, pursuant to this release authorization will be considered in determining my suitability for issuance of a license to carry a concealed firearm by the Westerly Police Department. I have had explained to me, and I fully understand, that refusal to grant this authorization will not, of itself, constitute a basis for rejection of my application.

To the custodian of the records discussed herein, I hereby authorize you to release information to the bearer of this *Authorization for Release of Information.* I consider a copy of the *Authorization for Release of Information* to be as valid as the original even though a copy does not have my original signature.

I hereby release to the Westerly Police Department and its agents and anyone who gives written or oral information about me *to* the Westerly Police Department from any claims of liability or damages which may occur as a result of the background investigation. This release of liability also extends to my heirs, executors, assigns and representatives.

Print Name: _____ Date of Birth: _____

Signature: _____ Soc. Sec. #:_____

Address: _____

Lawrence + Memorial Hospital YaleNewHaven**Health**

Authorization for Access/Release of Information

Patient Name: _____ _____ _____ _____
(Last) (First) (Middle Initial) (Maiden/Other Name)

Date of Birth: _____ **Phone:** _____ **Email:** _____

_____

Complete Address (street or box#, city, state, zip)

This information is to be used for purpose of: ☐ Personal use ☐ Continuing care ☐ Legal ☐ Disability ☐ Workers Comp
☐ Insurance Eligibility/Benefits ☐ Social Security Card ☑ Other **Conceal Carry Permit**

I hereby authorize Lawrence + Memorial Hospital to:

☑ **RELEASE information from my medical record TO:** ☐ **OBTAIN information FROM:**

Name: **Westerly Police Department Attn: Det. Matthew Hayden** **Phone:** **401-348-6134**

Address: **60 Airport Rd.** **City/State:** **Westerly, RI** **Zip Code:** **02891**

Fax (optional): **401-596-4641** **Email** (optional): **mhayden@westerlypolice.org**

Method of Disclosure: ☐ MyChart (Must have active account) ☑ Mail ☑ Fax ☑ Secure Email
☐ Pick-up Please indicate how you would like to be contacted when ready for pick-up: _____ Format: ☐ CD-ROM

Visit Type: ☑ Admission ☑ Outpatient Surgery ☑ Emergency Dept. Visit ☑ Physician Office/Clinic ☐ Other _____

Date(s) of Service: **2000-present**

Medical Information Requested:

☑ Abstract of Medical Record (History & Physical Exam, Discharge Summary, Consult Report, ED Report, Operative Report, Pathology Report, Lab Results, Radiology Report)

☐ History & Physical Exam/HP	☐ Lab Results	☐ Stress Test	☐ Consult Report
☐ Discharge Summary/DS	☐ Radiology Report	☐ Echocardiogram/EKG	☐ Clinic/Office Notes
☐ Emergency Visits/ED	☐ Pathology Report	☐ Pulmonary Function Test	☑ Medication List
☐ Operative/Procedure Report	☐ Immunization Record	☐ PT/OT/Speech Notes	☑ Other **Mental Health Only**

☐ Complete Medical Record *(Includes all of the above, plus nursing notes, ancillary notes, and consents. Excludes nursing flowsheets unless specifically requested)*.

☐ Itemized Bill ☐ Radiology Image(s): _____
Please note date and type

Reasonable cost-based fees apply.

*****HIV-BEHAVIORAL HEALTH- DRUG/ALCOHOL INFORMATION** contained within the medical records indicated above will be released through this authorization unless otherwise indicated below. **(Medical records containing any of the protected information below must also be signed by the patient if a minor age 13 or older, with the exception of Behavioral Health, which also requires authorization by the patient if a minor age 16 or older.)*****

Indicate which you do NOT want released with your initials:

____ HIV ____ Substance Abuse (which includes Alcohol & Drug Abuse) ____ Pregnancy Test ____ Genetic Testing

____ Behavioral Health/Psychiatric ____ Sexually Transmitted Disease ____ Other (please list) _____

I understand that:

- This authorization is valid for one year from the date below. I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by contacting in writing Lawrence + Memorial Hospital Release of Information Services. Cancellation of the authorization will not apply to information that has already been released based on this authorization.
- The information disclosed in response to this authorization may be subject to re-disclosure by recipient, and will no longer be protected under the terms of this authorization or by federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
- That this authorization is voluntary and my treatment by Lawrence + Memorial Hospital is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. If I do not sign this form, payment for this care will only be affected if my health care insurer is requesting this information and is permitted to require this authorization.
- On request, I may review or have copied the information described on this form if I ask for it. There may be a charge for copies in accordance with Connecticut law.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) unless the records relate to treatment(s) for which the minor may provide consent under CT state law. If HIV, Behavioral Health, Drug/Alcohol information is included for a patient age 13 or older, the minor must sign as described above.

Return completed authorization by mail, fax, or email as designated below. Do not send medical records to this address.

Mailing Address: **Lawrence + Memorial Hospital**
Health Information Management
Release of Information Services
365 Montauk Avenue
New London, CT 06320

Fax Number: **(860) 444-3760** **Email to: releaseofinfo@lmhosp.org**

Routine requests for medical records are generally processed within 10 business days. To contact a Customer Service Representative, please call (860) 444-3704.

Printed Name: _____ Date: _____

Print Form and Sign Here

_____
Signature of Patient or Authorized Representative
***must provide proof of authority (except parent of a minor)*

Please check relationship to patient

☐ Self ☐ Parent ☐ Legal Guardian ☐ Executor/Administrator of Estate ☐ Healthcare Representative ☐ Conservator

☐ Other Authorized Legal Representative _____ (indicate)

Printed Name of Minor (when applicable)	Signature of Minor (when applicable)	Date

Yale Medicine YaleNewHaven**Health**

Authorization for Access/Release of Information

Legal Name: _____ _____ ___ _____ _____
(Last) (First) M.I. Preferred Name (Maiden/Other Name)

Date of Birth: _____ **Phone:** _____ **Email:** _____

Complete Address (street or box#, city, state, zip)

This information is to be used for purpose of: ☐ Personal use ☐ Continuing care ☐ Legal ☐ Disability ☐ Workers Comp
☐ Insurance Eligibility/Benefits ☐ Social Security Card ☑ Other Conceal Carry Permit

I hereby authorize Yale New Haven Health/Yale Medicine entity(ies) named below to:

☑ **RELEASE information from my medical record TO:** ☐ **OBTAIN information FROM:**

Name: Westerly Police Department ATTN: Det Matthew Hayden **Phone:** 401-348-6134

Address: 60 Airport Rd. **City/State:** Westerly, RI **Zip Code:** 02891

Fax (optional): 401-596-4641 **Email** (optional): mhayden@westerlypolice.org

If medical records are being requested from an external provider/facility for patient care at YNHHS, please provide name of YNHHS location to send medical information:

YNHHS Provider Name: _____

Complete Address: _____

Fax Number: _____ Phone Number: _____

Method of Disclosure: ☐ MyChart (Must have active account)
☑ Mail ☑ Fax ☑ Secure Email ☐ Pick-up Please indicate how you would like to be contacted when ready for pick-up: _____

Visit Type: ☑ Admission ☑ Outpatient Surgery ☑ Emergency Dept. Visit ☑ Physician Office/Clinic ☐ Other _____

Location: ☑ Yale New Haven Hospital (York Street Campus/St. Raphael's Campus/Smilow Care Centers)
☑ Bridgeport Hospital (includes Milford Campus after 6/8/2019) ☑ Milford Hospital (prior to 6/9/2019) ☑ Greenwich Hospital
☐ NEMG Provider Practice Name: _____
☐ Yale Medicine Provider Practice Name: _____

Date(s) of Service: 2000 - Present

Medical Information Requested:

☑ Abstract of Medical Record (History & Physical Exam, Discharge Summary, Consult Report, ED Report, Operative Report, Pathology Report, Lab Results, Radiology Report)

☐ History & Physical Exam/HP	☐ Lab Results	☐ Stress Test	☐ Consult Report
☐ Discharge Summary/DS	☐ Radiology Report	☐ Echocardiogram/EKG	☐ Clinic/Office Notes
☐ Emergency Visits/ED	☐ Pathology Report	☐ Pulmonary Function Test	☑ Medication List
☐ Operative/Procedure Report	☐ Immunization Record	☐ PT/OT/Speech Notes	☑ Other Mental Health Only

☐ Complete Medical Record *(Includes all of the above, plus nursing notes, ancillary notes, and consents. Excludes nursing flowsheets unless specifically requested)*.

☐ Itemized Bill ☐ Radiology Image(s): _____
Please note date and type

Reasonable cost-based fees apply.

*****HIV-BEHAVIORAL HEALTH- DRUG/ALCOHOL INFORMATION** contained within the medical records indicated above will be released through this authorization unless otherwise indicated below. **(Medical records containing any of the protected information below must also be signed by the patient if a minor age 13 or older, with the exception of Behavioral Health, which also requires authorization by the patient if a minor age 16 or older.)*****

Indicate which you do NOT want released with your initials:

____ HIV ____ Substance Abuse (which includes Alcohol & Drug Abuse) ____ Pregnancy Test ____ Genetic Testing

____ Behavioral Health/Psychiatric ____ Sexually Transmitted Disease ____ Other (please list) _____

I understand that:

- This authorization is valid for one year from the date below. I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by contacting in writing YNHHS Release of Information Services. Cancellation of the authorization will not apply to information that has already been released based on this authorization.
- The information disclosed in response to this authorization may be subject to re-disclosure by recipient, and will no longer be protected under the terms of this authorization or by federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
- That this authorization is voluntary and my treatment by YNHHS/Yale Medicine is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. If I do not sign this form, payment for this care will only be affected if my health care insurer is requesting this information and is permitted to require this authorization.
- On request, I may review or have copied the information described on this form if I ask for it. There may be a charge for copies in accordance with Connecticut law.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) unless the records relate to treatment(s) for which the minor may provide consent under CT state law. If HIV, Behavioral Health, Drug/Alcohol information is included for a patient age 13 or older, the minor must sign as described above.

Return completed authorization by mail, fax, or email as designated below. Do not send medical records to this address.

Mailing Address: **Yale New Haven Health**
Health Information Management
Release of Information Services
PO Box 9565
New Haven, CT 06535

YNHHS Hospital(s) Fax Number:	**203-688-4645**	**Email to: releaseofinfo-Hosp@ynhh.org**
NEMG Provider Fax Number:	**203-200-1286**	**Email to: releaseofinfo-NEMG@ynhh.org**
YM Provider Fax Number:	**203-200-1287**	**Email to: releaseofinfo-YM@ynhh.org**

Routine requests for medical records are generally processed within 10 business days. To contact a Customer Service Representative, please call 203-688-2231.

Printed Name: _____ Date: _____

Print Form and Sign Here

_____
Signature of Patient or Authorized Representative
***must provide proof of authority (except parent of a minor)*

Please check relationship to patient

☐ Self ☐ Parent ☐ Legal Guardian ☐ Executor/Administrator of Estate ☐ Healthcare Representative ☐ Conservator

☐ Other Authorized Legal Representative _____ (indicate)

Printed Name of Minor (when applicable)	Signature of Minor (when applicable)	Date

Yale NewHaven Health
Westerly Hospital

Authorization for Release of Information

Patient Legal Name: _____ (Last) _____ (First) ___ M.I. _____ Preferred Name _____ (Maiden/Other Name)

Date of Birth: _____ **Phone:** _____ **Email:** _____

Patient's Address: _____
(po box # or street, city, state, zip code)

This information is to be used for purpose of: ☐ Personal use ☐ Continuing care ☐ Legal ☐ Disability ☐ Workers Comp

☐ Insurance Eligibility/Benefits ☐ Social Security Claim ☐ Veterans Benefits ☐ Other _____

Release information from my medical record to:

Name: Detective Matthew Hayden Westerly Police Department Phone: (401) 348-6134

Address: 60 Airport Rd. Westerly, RI 02891
Street City State Zip Code

Delivery Method: (Choose one only)

☐ MyChart patient portal (Must have active account. To activate your account go to mychart.ynhhs.com)

☑ Mail ☑ Fax (Please enter the fax number): 401-596-4641

☑ Secure Email: mhayden@westerlypolice.org ☐ Pick Up/Hand Carry Format: ☐ CD-ROM

Information to be sent:

Date of Service(s): _____ **Or Date Range From:** 2000 **To:** Present

Medical Information Requested:

☐ Hospital Admission Abstract (Includes: History & Physical Exam, Discharge Summary, Consult Report, ED Report, Operative Report, Pathology Report, Lab Results, Radiology Report)

☐ Outpatient Visit Notes	☐ History & Physical Exam/HP	☐ Stress Test	☐ Consult Report
☐ Discharge Summary/DS	☐ Lab Results	☐ Echocardiogram/EKG	☐ Immunization Record
☐ Emergency Visits/ED	☐ Radiology Report	☐ Pulmonary Function Test	☑ Medication List
☐ Operative/Procedure Report	☐ Pathology Report	☐ PT/OT/Speech Notes	☑ Other: Mental Health Only

☐ Complete Medical Record *(Excludes data collection flowsheets unless specifically requested).* ☐ Include Flowsheets

Items requested below will be sent separate from medical records:

☐ Radiology Images: Please specify date and type of test: _____

☐ Itemized Bill: Please specify date of service: _____

SENSITIVE INFORMATION: All information selected on page 1 will be disclosed with this authorization unless specifically requested to be excluded as indicated below. Please do NOT include the following information:

☐ HIV ☐ Behavioral Health/Psychiatric ☐ Substance Abuse (which includes Alcohol & Drug Abuse)
☐ Termination of Pregnancy ☐ Sexually Transmitted Disease ☐ Genetic Testing
☐ Other: _____

I understand that:

- This authorization is valid for one year from the date below. I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by contacting in writing Westerly Hospital Release of Information Services. Cancellation of the authorization will not apply to information that has already been released based on this authorization.
- The information disclosed in response to this authorization may be subject to re-disclosure by recipient, and will no longer be protected under the terms of this authorization or by federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
- That this authorization is voluntary and my treatment by Westerly Hospital is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. If I do not sign this form, payment for this care will only be affected if my health care insurer is requesting this information and is permitted to require this authorization.
- On request, I may review or have copied the information described on this form if I ask for it. There may be a charge for copies in accordance with Rhode Island law.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) unless the records relate to treatment(s) for which the minor may provide consent under Rhode Island state law. If HIV, Behavioral Health, Drug/Alcohol information is included, the minor must sign as described above.

***** Medical records containing protected information under applicable federal or state laws must also be authorized by a minor when age 13 or older (e.g. HIV, substance abuse (including alcohol & drug abuse), termination of pregnancy, and/or sexually transmitted disease). For behavioral health, the patient if a minor age 16 or older is also required to authorize release of medical records.**

Return completed authorization by mail, fax, or email as designated below. Do not send medical records to this address.

Mailing Address: **Westerly Hospital**
Health Information Management
Release of Information Services
25 Wells Street
Westerly, RI 02891

Westerly Hospital Fax Number: 401-348-3774 **Email to: releaseofinfo@westerlyhospital.org**

Routine requests for medical records are generally processed within 10 business days. To contact a Customer Service Representative, please call 401-348-3262.

Printed Name: _____ Date: _____

_____
Signature of Patient or Authorized Representative
***must provide proof of authority (except parent of a minor)*

Please check relationship to patient

☐ Self ☐ Parent ☐ Legal Guardian ☐ Executor/Administrator of Estate ☐ Healthcare Representative ☐ Conservator

☐ Other Authorized Legal Representative _____ (indicate)

Printed Name of Minor (when applicable)***	Signature of Minor (when applicable)***	Date
_____	_____	_____

Gateway Healthcare
BROWN Health
UNIVERSITY

Gateway Healthcare
Health Information Department
1 Virginia Avenue, suite 200
Providence, R.I. 02905
Tel: 401-667-6567
Fax: 401-444-2365

Authorization to Use or Disclose Protected Health Information

(This form must be completed in full before signing)

Patient Name _____ DOB _____ Phone _____

Address _____
Street City State ZIP

1. I hereby authorize Gateway Healthcare to: ☒ Release to ☐ Obtain from ☐ Verbal Communication

2. Westerly Police Department / ATTN: Det. Matthew Hayden
Person / Place / Institution

60 Airport Rd. Westerly RI 02891 401-348-6134
Street City State ZIP Phone

3. *Dates of treatment or time period* 2000 to Present

4. *Purpose for which disclosure is to be made:* ☐ *Coordination of Care* ☐ *Patient Request* ☐ *Legal.*

X Other (please specify): Conceal Carry Permit

5. Record Format-please check one: ☒ Paper ☐ CD disc.

6. Information to be disclosed (check all applicable): *There may be a fee associated with this request.*

☐ Emergency Dept. Record ☐ Operative/Path Report ☐ Lab/X-ray Reports ☐ Other Diagnostic Testing

☐ Clinic/Office Visit ☐ Consultation / Evaluation ☐ After Visit Summary

☒ Abstract* ☐ Discharge Summary ☒ Other MENTAL HEALTH ONLY

*Abstract includes: Facesheet, ED Record, H & P, D/C Summary, Consult, Operative report, Pathology report, test results, PT/OT/ ST

For Behavioral Health: ☐ Assessment ☐ Treatment Plan ☐ Psychiatric Evaluation ☐ Medications ☐ Progress Notes

7. I do **not** want the following information disclosed: ☐ mental health ☐ alcohol/drug use/test

☐ sexual abuse ☐ sexually transmitted infections ☐ AIDS/HIV test results

8. I understand that my records are protected under the federal privacy laws and regulations and under the General Laws of Rhode Island and cannot be disclosed without my written consent except as otherwise specifically provided by law. I also understand that certain health records containing alcohol or drug abuse information may be subject to further protection under Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse.

9. I understand that if the person(s) or entity (ies) that receive(s) this information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Gateway Healthcare, its employees and my physicians from all liability arising from this disclosure of my health information.

10. It is my understanding that this authorization is for information we have at the time of your request, only for the information requested above and will expire 1 year from the date signed below. I understand that I may revoke this authorization by notifying Gateway Healthcare in writing. I understand that any previously disclosed information would not be subject to my revocation request.

11. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits, unless otherwise described in the space provided here:

_____ _____
Signature of Patient*, Legal Guardian, or Representative Date Time

_____ _____
Print name of Patient, Legal Guardian or Representative Date Time

Rev: 1 2016, GW revised 7/2016, GW revised 8 2017, GW REV: 10 01 2020, 10/2024 ☐ Mail Out or ☐ File Only