



**Michelle Rickerby MD**

Family Psychiatry Collaborative, LLC  
Suite 100, 285 Governor Street  
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401-270-1060 (ph)  
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**AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION**

Patient Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Medical Record # (or SS#) \_\_\_\_\_

1. I authorize Michelle Rickerby MD and Family Psychiatry Collaborative LLC to disclose my health information to:

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I authorize: \_\_\_\_\_  
to disclose my health information to Michelle Rickerby MD and Family Psychiatry Collaborative of Suite 100, 285 Governor Street, Providence, RI 02906

2. For the following date or time period: \_\_\_\_\_

3. Purpose for which disclosure is to be made: \_\_\_\_\_

4. Method of release:        \_\_\_ Telephone/Verbal        \_\_\_ Fax        \_\_\_ Photocopies

5. Information to be disclosed (check all applicable):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Emergency Dept. Record | <input type="checkbox"/> Neuropsychological Evaluation | <input type="checkbox"/> Psychiatric Exam      |
| <input type="checkbox"/> Entire Medical Record  | <input type="checkbox"/> Neurological Evaluation       | <input type="checkbox"/> Progress Notes        |
| <input type="checkbox"/> Discharge Summary      | <input type="checkbox"/> Medication List               | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Radiology Report       | <input type="checkbox"/> History & Physical Exam       | <input type="checkbox"/> Treatment Plan        |
| <input type="checkbox"/> EKG                    | <input type="checkbox"/> Pathology Report              | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> EEG                    | <input type="checkbox"/> Operative Report              | _____  |
| <input type="checkbox"/> MRI/CT                 | <input type="checkbox"/> Laboratory Report             |  |
| <input type="checkbox"/> EMG                    | <input type="checkbox"/> Consultation Report           |  |

6. I understand that this will include health information relating to (Check if applicable):

- Mental Health                       Treatment for Alcohol and/or Drug Abuse



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- Sexually Transmitted Disease       HIV (Human Immunodeficiency Virus)
7. I understand that my records are protected under the federal privacy regulations and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law. Further, I understand that if my records involve alcohol and/or drug abuse, they are also protected under the Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.
  8. I understand that if the person (s) or entity (ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is longer protected by those regulations. Therefore, I release Michelle Rickerby MD/ Family Psychiatry Collaborative, LLC, from all liability arising from this disclosure of my health information.
  9. It is my understanding that this authorization will expire one year from the date signed below. I understand that may revoke this authorization by notifying Michelle Rickerby MD /Family Psychiatry Collaborative, LLC in writing understand that any previously disclosed information would not be subject to my revoked request.
  10. I have read carefully and understand the above statements and do herein expressly and voluntarily consent to disclosure of the above information and/or medical records to those persons/agencies named above.

**This form must be fully complete before signing.**

\_\_\_\_\_  
**Signature of Patient or Patient's Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Patient's Name**

\_\_\_\_\_  
**Print Name of Legal Representative (if applicable)**

\_\_\_\_\_  
**Relationship to Patient**