RISD Health Services
20 Washington Place
Providence, RI 02903
(401) 454-6625 (phone)
(401) 454-6628 (fax)

Medical Records Request/Release Authorization

Section 1 - Student Information

Name:	ID#:
Date of Birth:	Phone #:

Section 2 - Disclosure

I, the undersigned, authorize Rhode Island School of Design to ☐ release to / ☐ request from

Name:	Address:
Phone:	Fax:

The following medical records:

I authorize the release of my complete Health Services record (including records relating to mental health, drug or alcohol use, sexually transmitted infections, interpersonal violence history, gender identity information, and HIV-related information, including testing).

OR

I authorize the release of my complete health record with the exception of the following information:

☐ Mental health
☐ Alcohol or drug use
☐ Sexually transmitted infections
☐ Interpersonal violence history
☐ Gender identity information
☐ HIV-related information, including testing
☐ Other (Please specify): ______________________________

OR

I authorize the release if the following limited information:

☐ Appointment History
☐ Last note/summary
☐ Other (Please Specify): ______________________________

Section 3 - Method of Transmittal

Please use the following method of record transmittal:

Fax
Mail
Verbal communication
Digitally via a protected/encrypted email (specify email) ______________________
I, the student/patient, will pick up personally

Section 4 - Authorization

I certify that this request has been made voluntarily and that the information given above is complete and accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken to comply with it. Without my express written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event on the earlier of _____ (date), or 180 days from the date below. A facsimile or photocopy of this authorization shall be considered as effective and valid as the original. I hereby release Rhode Island School of Design, its employee and agents, from any liability to me or anyone claiming by, through, or under me, which may arise directly or indirectly out of the College's good faith compliance with this authorization.

I have read this authorization prior to signing and I understand its contents.

Signed: ______________________________	Dated:

Relationship to student: ☐ Self ☐ Other: ______________________________

3/2024