TDI-Release Form (rev. 1-10)

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Labor and Training
Temporary Disability Insurance
Center General Complex
P.O. Box 20070
Cranston, RI 02920-0941

Telephone: (401) 462-8420 Fax: 401-462-8466
TDD: (401) 462-8006

Donald L. Carcieri
Governor
Sandra M. Powell
Director

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please deliver this signed medical release form to your Qualified Healthcare Provider (Physician, Hospital, or Medical Facility) immediately. Failure to do so may delay the processing of your TDI claim. <u>DO NOT DELIVER TO TDI</u>.

Healthcare Provider Name:
Address::
Address:

Patient's Social Security #:
Patient's Name:
Patient's Address:

You are hereby authorized to furnish and release to the Rhode Island Department of Labor & Training, Temporary Disability Insurance Division (TDI), any and all information and records it requests concerning findings and treatment rendered and opinions as to my condition, including authorization to release Mental Health, Behavioral Health, Psychiatric Records or Psychotherapy Notes as a result of my illness and or injury for which I received treatment commending on: Date:___________________

Protected Health Information to be disclosed:
All the medical records for the illness or injury for which I am claiming TDI benefits as of my unable to work date of: Date:_______________________

I understand that my records are protected under federal privacy laws and regulations and under the RIGL and cannot be disclosed without my written consent except as otherwise provided by law. I also understand that if my records involve alcohol or drug abuse or HIV (AIDS) testing, they are further protected under Federal Regulations 42 CFR part 2, Confidentiality of Alcohol and Drug abuse. I hereby release the above named healthcare provider from all liability arising from this disclosure of my protected health information.

This authorization will expire upon my completion of treatment for this illness and/or injury or within six (6) months from the date signed below whatever is the later, and it may be withdrawn at any time by submitting written notification of its withdrawal.

_______________________________________ _______________

Signature of Patient or Patient's Legal Representative Date

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An Equal Opportunity Employer/Program. Auxiliary aids and services are available upon request for individuals with disabilities.