



CARDIOVASCULAR INSTITUTE OF NEW ENGLAND, P.C.

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CONSENT FOR RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION

I hereby authorize **Cardiovascular Institute of New England**, (The Medical Practice"), to release and/or transfer all records, opinions, reports, x-rays, laboratory test and analysis, photo static copies, abstracts or excerpts of any medical records or other information of any kind relating to the undersigned in the possession of the medical practice (hereinafter collectively referred to as "Confidential Health Care Information", including those results related to HIV, for purpose of coordinating my health care and/or coordinating the payment of claims of my health insurer. Provided, however, that this consent for the release of "confidential health care information" shall not apply to the "confidential health care connection with the performance of any federally assisted alcohol and drug abuse program.

I understand that I may WITHDRAW the consent for the release and/or transfer of my confidential health care information" in writing at any future time.

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 fax 401.762.8252

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 CRANSTON, RI 02920
 401.464.9751
 fax 401.464.9755

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 WESTERLY, RI 02891
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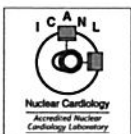
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You can fax or mail the release to our office. We have 30 days upon receipt of this request to forward your records.

Thank You



*Teaching appointee of

