



## **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.
4. 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. A forty (\$40.00) dollar check or money order, made payable to the Town of Westerly must be presented upon issuance of the license. Do not send a check or money order with your application.
8. **NEW** applicants must be fingerprinted and sign an FBI fingerprint application card (FD-258 Rev. 12-29-82). 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.



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:

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

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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:

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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:

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

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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 IDENTIFICATION INCLUDE: BIRTH CERTIFICATE, RHODE ISLAND OR STATE OPERATOR'S LICENSE, RHODE ISLAND IDENTIFICATION CARD, PASSPORT, OR OTHER AUTHENTIC FORMS OF POSITIVE IDENTIFICATION.

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 STATUTES PERTAINING TO FIREARMS 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

**Arbour-Fuller Hospital**  
200 May Street  
South Attleboro, MA 02703-5515  
(508) 761-8500/FAX (508) 761-4240

**AUTHORIZATION TO OBTAIN/RELEASE INFORMATION**

Patient: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient's Address: \_\_\_\_\_

I hereby authorize Arbour-Fuller Hospital to:  Obtain From **AND/OR**  Release To

Facility: Westerly Police Department

Address: 60 Airport Road Westerly, RI 02891

ATTN: \_\_\_\_\_ Fax # (if applicable): \_\_\_\_\_

The following information contained in the medical record of the above named patient pertaining to services provided on or about \_\_\_\_\_ . Please check the appropriate information to be released:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Admission Note       | <input checked="" type="checkbox"/> Psychological Testing  | <input checked="" type="checkbox"/> Rehab Assessments |
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Laboratory Data   | <input type="checkbox"/> Aftercare Plan               |
| <input type="checkbox"/> Physical Examination | <input checked="" type="checkbox"/> Treatment Plans  |   |
| <input type="checkbox"/> Medical Consult      | <input checked="" type="checkbox"/> Other (please be specific) <u>Mental Health, Alcohol, Drug Treatment</u> |   |

The information is needed for the following purpose(s) and may not be redisclosed:

- To provide ongoing treatment/aftercare.  
 Other: License to Carry Concealed Firearm

I understand that records which refer to treatment of diagnosis of drug or substance abuse are protected under the Federal Regulations (42CFR, Part 2), Confidentiality of Alcohol and Drug Abuse Treatment.

I have read carefully and understand the above statements and do herein expressly and voluntarily consent to disclosure of the above information and/or psychiatric records including alcohol and drug abuse records, if applicable, to those persons/agencies named above.

I further release the Hospital and its employees from any liability arising from the release of this information to such persons/agencies, provided said release of information is done substantially in accordance with applicable law.

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 thereunder.

Once the requested PHI is disclosed, the Privacy Regulations may no longer protect it if the PHI's recipient rediscloses it.

I understand this consent is subject to revocation at any time unless action based on it has already begun. This authorization will automatically expire 90 days from the date it is signed.

My records  may  may not be faxed. \_\_\_\_\_ (please initial).

\_\_\_\_\_  
Signature of Patient/Legal Guardian or Relationship to Patient Date: \_\_\_\_\_  
Parent if Patient is Under 18

Witness: \_\_\_\_\_ Adolescent Signature : \_\_\_\_\_

**AUTHORIZATION to RELEASE H.I.V. INFORMATION**

I hereby specifically authorize the release of HIV antibody or antigen testing or records containing HIV, HIV virus or any AIDS related conditions which may be contained in the above referenced request.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## 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.

**BUTLER HOSPITAL**  
**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please Print)

I authorize the use and/or disclosure of the above-named individual's health information as described in this authorization. I, therefore, authorize Butler Hospital, 345 Blackstone Boulevard, Providence, Rhode Island 02906 to:

Release to:  Request from:

Agency Name (If Applicable): Westerly Police Department

Name (First and Last): \_\_\_\_\_

Street Address: 60 Airport Road

City/State/Zip Code: Westerly RI 02891

This authorization will have a duration of consent no longer than 90 days after the date of this form or for the duration of treatment should the duration of treatment be longer than 90 days. Information may be released by the following methods:

Telephone/Verbal Phone #: \_\_\_\_\_  
 Photocopies  
 FAX Fax#: \_\_\_\_\_

**Information to be released includes:**

Discharge Summary  Psychiatric Exam  Treatment Plan  Progress Notes  
 Psychological Test  History and Physical  Laboratory Data Including HIV  
 Other (Please be specific): \_\_\_\_\_  
For Dates of Service: 1990-Present

DO NOT RELEASE:  HIV Test  Other (Specific): \_\_\_\_\_

The purposes of the request are described below (each purpose must be listed):

\_\_\_\_\_

At the request of the individual for his/her own purposes.

I understand that the information in the health record may relate to treatment for alcohol and drug abuse and/or the results of diagnostic tests used to determine if the individual is infected by the human immunodeficiency virus (HIV). Unless I have indicated otherwise above, I specifically authorize the release of this information.

I understand that I have the right to revoke (cancel) this authorization at any time. I understand that to revoke this authorization, I must contact the Director of Medical Records at Butler Hospital and will be required to put my revocation (cancellation) in writing. I understand that the revocation will not be effective until it is received, and it will not apply to information that has already been released in response to this authorization. I also understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that signing this authorization is voluntary and that Butler Hospital will provide treatment and pursue payment for service regardless of whether I sign this authorization.

I understand that if I authorize Butler Hospital to disclose information, the recipient of the information might disclose it to others, and that any information disclosed by Butler Hospital may no longer be protected by the federal rule on privacy of medical records.

\_\_\_\_\_  
Patient Signature or authorized Representative      Date      Witness Signature      Date

\_\_\_\_\_  
Representative      Relationship      Printed Name of Authorized

Send Aftercare Information:  
Patient's Appointment      Date: \_\_\_\_\_      Time: \_\_\_\_\_



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES 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 conceal 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: \_\_\_\_\_



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

**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 Subject 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

**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

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



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):

- DRUG ABUSE, ALCOHOLISM OR ALCOHOL ABUSE, SICKLE CELL ANEMIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV)

DESCRIPTION OF INFORMATION REQUESTED

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

- 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, OTHER (Describe): Copy of outpatient Treatment Note(s)

PURPOSE(S) OR NEED

Information is to be used by the individual for:

- TREATMENT, BENEFITS, LEGAL, 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
<b>AUTHORIZATION</b>			
<p>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.</p> <p>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.</p>			
<b>EXPIRATION</b>			
Without my express revocation, the authorization will automatically expire.			
<input type="checkbox"/> UPON SATISFACTION OF THE NEED FOR DISCLOSURE <input type="checkbox"/> ON _____ (enter a future date other than date signed by patient) <input type="checkbox"/> 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	
<b>FOR VA USE ONLY</b>			
TYPE AND EXTENT OF MATERIAL RELEASED			
DATE RELEASED		RELEASED BY:	



### 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. \_\_\_\_\_  
Person / Place / Institution

\_\_\_\_\_ Street City State ZIP Phone

3. Dates of treatment or time period \_\_\_\_\_

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

Other (please specify): \_\_\_\_\_

5. Record Format-please check one:  paper  data storage device

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 \_\_\_\_\_

\*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.

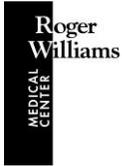
9. I understand that if the person(s) or entity (ies) that receive(s) this information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Gateway Healthcare,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



**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)

- |   |  |
|---|--|
| <input type="checkbox"/> Roger Williams Medical Center              | <input type="checkbox"/> St. Joseph Health # |
| <input type="checkbox"/> Our Lady of Fatima =                       | <input type="checkbox"/> # # k- U **         |
| <input type="checkbox"/> Southern New England Rehabilitation Center |  |

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**

**Purpose** (check the appropriate box)

\_\_\_\_\_  
Name

- Medical Care
- Legal Matter
- Insurance
- Personal

\_\_\_\_\_  
Address

Other (please specify) \*

\_\_\_\_\_  
City, State, Zip Code

\* \_\_\_\_\_

**Concerning my treatment for the period of:** \_\_\_\_\_

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

- |  |  |
|--|--|
| <input type="checkbox"/> Discharge Summary (dates) _____   | <input type="checkbox"/> Pathology Reports (dates) _____ |
| <input type="checkbox"/> Operative Reports (dates) _____   | <input type="checkbox"/> Emergency Room (dates) _____    |
| <input type="checkbox"/> Outpatient Test Results (dates) _____   | <input type="checkbox"/> Lab Reports (dates) _____       |
| <input type="checkbox"/> X-Rays/Scan Reports (dates) _____   | <input type="checkbox"/> Other (please specify) _____    |
| <input type="checkbox"/> Reports   | <input type="checkbox"/> Films                           |
|  | <input type="checkbox"/> Billing _____                   |
| <input type="checkbox"/> Medical Record Abstract (e.g. Discharge Summary, Consultations, History & Physical, Operative, Pathology, and Test Reports) |  |



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 \_\_\_\_\_ 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 401-348-8080

## 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 401-348-8080

## 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: \_\_\_\_\_

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

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: Phone:

Address: City/State: Zip Code:

Fax (optional): Email (optional):

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:

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

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: <a href="mailto:releaseofinfo-Hosp@ynhh.org">releaseofinfo-Hosp@ynhh.org</a>
NEMG Provider Fax Number:	203-200-1286	Email to: <a href="mailto:releaseofinfo-NEMG@ynhh.org">releaseofinfo-NEMG@ynhh.org</a>
YM Provider Fax Number:	203-200-1287	Email to: <a href="mailto:releaseofinfo-YM@ynhh.org">releaseofinfo-YM@ynhh.org</a>

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: \_\_\_\_\_

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 \_\_\_\_\_

