

**RHODE ISLAND DEPARTMENT OF HEALTH  
REQUEST FOR RELEASE OF RECORDS**

Please complete this form and mail it to Rhode Island Department of Health, 3 Capitol Hill, Room 401, Providence, RI, 02908; or fax it to 222-6548; or e-mail it to website.doh@health.ri.gov

REQUESTED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS : \_\_\_\_\_ PHONE: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ FAX: \_\_\_\_\_

**IT IS MY UNDERSTANDING THAT USE OF THIS INFORMATION FOR COMMERCIAL PURPOSES AS DEFINED IN SECTION 38-2-6 OF THE RI GENERAL LAWS IS PROHIBITED AND COULD RESULT IN THE IMPOSITION OF FINES AND/OR IMPRISONMENT.**

**SIGNATURE:** \_\_\_\_\_

**FOR PERSONS REQUESTING CONFIDENTIAL INFORMATION:** Persons must demonstrate that they have an interest in the requested record(s) which is such as would enable them to maintain or defend a legal action for which the document or record sought can furnish evidence or necessary information, or are otherwise entitled to the record by law.

**REQUESTED RECORDS**

For record requested, please be specific as possible, citing correct dates, names, addresses, etc., if applicable. Also, please include what format is needed (i.e., photocopy, diskettes, mailing labels).

**FOR DOH USE ONLY**

**REQUEST GRANTED**

**\$ \_\_\_\_\_ TOTAL FEE**

**If fee is waived, state reason:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ **REQUEST DENIED**

**APPROVED BY:**

\_\_\_\_\_ **REFERRED TO LEGAL COUNSEL**

\_\_\_\_\_  
**(Chief Administrative Officer  
or Designee)**

**REASON:** \_\_\_\_\_

\_\_\_\_\_ **DATE:** \_\_\_\_\_