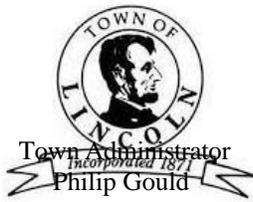


# WEAPONS CARRY PERMIT PACKET



## APPLICATION

APPLICATION INSTRUCTIONS FOR LICENSE TO CARRY  
A CONCEALED WEAPON



# Lincoln Police Department

100 Old River Road  
Lincoln, RI 02865  
(401) 333-1111  
*A State Accredited Agency*

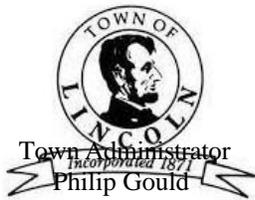


Chief of Police  
Dennis Fleming

## **NO APPLICATIONS WILL BE CONSIDERED UNLESS THE FOLLOWING HAVE BEEN COMPLETED:**

- 1) This official application form must be filled out completely by the applicant. Please **PRINT OR TYPE** the application or **IT WILL BE RETURNED.**
- 2) The application must be **NOTARIZED.**
- 3) Proof of qualification before a certified weapons instructor, i.e., NRA Instructor or Police range instructor must be supplied along with a copy of the instructor's NRA / FBI firearms instructor's instructor's certification.
- 4) Completion of a use of force training class, i.e., concealed carry course and/or basic pistol training.
- 5) Signed mental health inquiries. All **MUST** be signed even if you have never been a patient at the facility.
- 6) Two types of positive identification must be ~~submitted~~ photocopied, signed, and dated by a Notary Public, attesting to be true copies.
- 7) **ALL NON-RESIDENT APPLICANTS** must include a copy of their home state permit.

- 8) Retired Police Officers applying under 11-47-18 must submit a letter of verification from the Chief of Police of the department that they retired from standing that they have completed 20 years of GOOD service.
- 9) A \$75.00 fee will be collected at time of approval for Town Residents or Taxpayers. A \$200.00 fee will be collected for all non residents. This fee will be collected when the applicant is contacted for approval to complete their fingerprints, photo and conceal carry identification card.
- 10) The applicant will be notified by mail of approval or denial of a permit. If approved, the applicant must appear in person to pick up the permit. This application, fingerprint card, and photos become part of the records of the Town of Lincoln and will not be returned.
- 11) All permits will expire FOUR (4) years from the date of issue. Also, the renewal of your permit is your responsibility. No notification of the expiration of the permit will be sent to you. Allow a maximum of 90 days for processing of your application due to the fact that the Town of Lincoln is dependent on other agencies for the information necessary to complete the application.
- 12) There is no need to check status of an application. MOST applications will be approved within eight to ten weeks.



# Lincoln Police Department

100 Old River Road  
Lincoln, RI 02865  
(401) 333-1111  
*A State Accredited Agency*



Chief of Police  
Dennis Fleming

## APPLICATION FOR LICENSE TO CARRY A CONCEALED WEAPON

DATE: \_\_\_\_\_ PERMIT NUMBER: \_\_\_\_\_

NAME: \_\_\_\_\_  
Last First Middle

ADDRESS: \_\_\_\_\_  
Street Name and Number (No. P.O. Boxes Accepted) City or Town State & Zip

TELEPHONE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_  
Employer's Name  
Employer's Address Street and Number City or Town State & Zip

DETAIL JOB DESCRIPTION: \_\_\_\_\_  
\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ EYE COLOR: \_\_\_\_\_

HAIR COLOR: \_\_\_\_\_

ARE YOU A CITIZEN OF THE UNITED STATES? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

**(If you are not a citizen of the United States, a copy of both sides of your alien registration card must be included with this application.)**

LIST ALL ADDRESSES FOR THE LAST THREE YEARS, INCLUDING DATES AND LOCATIONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU EVER BEEN ARRESTED? \_\_\_\_\_

IF SO, GIVE DETAILS: \_\_\_\_\_

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HAVE YOU EVER BEEN UNDER GUARDIANSHIP OR CONFINED OR TREATED FOR MENTAL ILLNESS? \_\_\_\_\_

IF SO, GIVE DETAILS:

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---

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HAVE YOU EVER BEEN CONVICTED OF A CRIME? \_\_\_\_\_

IF SO, GIVE DETAILS: \_\_\_\_\_

---

---

HAVE YOU EVER PLED NOLO CONTENDRE TO ANY CHARGE OR VIOLATION? \_\_\_\_\_

IF SO, GIVE DETAILS \_\_\_\_\_

---

---

ARE YOU UNDER INDICTMENT IN ANY COURT FOR A CRIME PUNISHABLE BY IMPRISONMENT EXCEEDING ONE YEAR? \_\_\_\_\_

IF SO, GIVE DETAILS AND DATES: \_\_\_\_\_

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HAVE YOU APPLIED FOR A PERMIT TO CARRY A CONCEALED PISTOL OR REVOLVER FROM THE ATTORNEY GENERAL OR A LOCAL CITY OR TOWN IN RHODE ISLAND? \_\_\_\_\_

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IF SO, IDENTIFY THE AGENCY WHERE APPLICATION FILED:

\_\_\_\_\_ Agency \_\_\_\_\_  
IS IT CURRENTLY: ACTIVE \_\_\_\_\_ EXPIRED \_\_\_\_\_ DENIED \_\_\_\_\_  
REVOKED \_\_\_\_\_

**(If you hold an expired permit, enclose a photocopy, notary-signed and dated, attesting copies are true)**

HAVE YOU EVER APPLIED FOR A PISTOL PERMIT TO CARRY A HANDGUN  
IN ANOTHER STATE? \_\_\_\_\_ YES \_\_\_\_\_ NO  
IF YES, STATE AND CITY: \_\_\_\_\_

IF SO, IDENTIFY THE STATE WHERE THE APPLICATION FILED. \_\_\_\_\_  
IS IT CURRENTLY: ACTIVE \_\_\_\_\_ EXPIRED \_\_\_\_\_ DENIED \_\_\_\_\_  
REVOKED \_\_\_\_\_

**(If you hold an out-of-state permit, enclose a photocopy, notary-signed and dated, attesting copies are true)**

HAVE YOU EVER HAD A LEGAL NAME CHANGE? \_\_\_\_\_  
IF YES, STATE FORMER NAME: \_\_\_\_\_

PLEASE LIST ALL NICKNAMES OR ALIASES USED BY YOU:

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

TWO (2) TYPES OF POSITIVE IDENTIFICATION MUST BE SUBMITTED.  
EXAMPLES: (1) Birth Certificate (2) Rhode Island or State Driver's License  
(3) Rhode Island identification card (4) Passport.

A PHOTOCOPY OF ANY TWO OF THE ABOVE SIGNED AND DATED BY A NOTARY PUBLIC, ATTESTING AS BEING TRUE COPIES WILL BE ACCEPTED. PASSPORT AND OTHER POSITIVE IDENTIFICATION WILL ALSO BE ACCEPTED.

THREE (3) REFERENCES ARE REQUIRED:

Name	Address/City/State/Zip	Area Code/Tele No.	Years Known

NOTE: THE RI COMBAT COURSE IS FOR LAW ENFORCEMENT PERSONNEL ONLY. ALL OTHERS MUST QUALIFY IN ACCORDANCE WITH 11-47-15.

WEAPON QUALIFICATION SCORE: \_\_\_\_\_ CAL. OF WEAPON: \_\_\_\_\_

ARMY-L: SCORE: \_\_\_\_\_ R.I. COMBAT: \_\_\_\_\_ SCORE: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF N.R.A. INSTRUCTOR OR POLICE RANGE OFFICER      DATE

\_\_\_\_\_  
PRINTED NAME & TELEPHONE NO. OF N.R.A. INSTRUCTOR OR POLICE RANGE OFFICER

N.R.A. NUMBER OR POLICE DEPARTMENT NAME: \_\_\_\_\_

**AFFIDAVIT**

I CERTIFY THAT I HAVE READ AND I AM FAMILIAR WITH THE PROVISIONS OF 11-47-1 TO 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

BEFORE A NOTARY PUBLIC

SUBSCRIBED AND SWORN TO ME BEFORE IN RHODE ISLAND THIS \_\_  
DAY OF, 20\_\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC SIGNATURE

\_\_\_\_\_  
NOTARY PUBLIC (Name Printed)

MY COMMISSION EXPIRES ON: \_\_\_\_\_

**POLICY REGARDING THE ISSUANCE OF A LICENSE OR PERMIT TO  
CARRY A CONCEALED PISTOL OR REVOLVER PURSUANT TO RHODE  
ISLAND GENERAL LAWS, 11-47-11.**

**INTRODUCTION**

The Town of Lincoln is authorized by Rhode Island General Law 11-47-11 to issue a license or permit to carry a concealed pistol or revolver to a person twenty-one (21) years of age or over having a bona fide residence or place of business in Lincoln, or a person twenty-one (21) years of age or over having a bona fide residence within the United States who has already been issued a concealed weapon permit by another state or subdivision of the United States. The concealed weapon license shall be issued if the Town determines that the applicant has good reason to fear an injury to his or her person or property or has any other proper reason for carrying a pistol or revolver and that he or she is a suitable person to be so licensed.

Pursuant to Rhode Island General Law 11-47-18, an eligible person may make an application with the Attorney General for a license or permit to carry a pistol or revolver.

Pursuant to Rhode Island General Law 11-47-15, the applicant must also qualify to obtain a permit. The right to carry a loaded, concealed firearm in public is different from the right to purchase or possess a handgun in one's own home or business.

Rhode Island General Law 11-47-13 provides for the revocation of any such license or permit for just cause at any time by the granting authority.

The Town of Lincoln will exercise its discretion in a manner designed to protect the public at large as well as the individual applicant for a pistol permit.

The Town of Lincoln does not discriminate in the issuance of a pistol permit on grounds of race, sex, national origin, or any other reason prohibited by law.

## **PROCEDURE**

An applicant for a pistol permit must submit a completed application to the Lincoln Police Department, 100 Old River Road, Lincoln RI 02865. A permit fee of \$40.00 (non-refundable), payable by check or money order to the Town of Lincoln shall be assessed. The Lincoln Police Department will complete the required background which may include a check of court records and other sources for pending criminal cases, restraining orders, and/or discrepancies in the applicant's background, including prior history of mental illness.

The Town of Lincoln will not issue a pistol permit to any applicant who is prohibited from possessing or carrying a firearm under any State or Federal Law (e.g 18 U.S. 922(g)) or pursuant to any court order.

If this initial check does not disqualify the applicant from obtaining a pistol permit, the Town of Lincoln shall review the application on an individual basis to determine whether there has been good reason to fear an injury to his or her person or property or has any other proper reason for carrying a pistol or revolver, and that he or she is a suitable person to be so licensed, as required by the statute, and whether the applicant is qualified.

## **REASON STATEMENT**

In considering each individual application for a pistol permit, the Town of Lincoln must determine whether or not the applicant has demonstrated a good reason to fear an injury to his or her person or property or has any other proper reason for carrying a pistol or revolver, and that he or she is a suitable person to be licensed to carry a loaded firearm in public and consider the individual's demonstration of skill and responsibility to safely carry and use a firearm in compliance with all State, Federal, and local laws. Because a loaded, concealed firearm in untrained hands present a danger to the public and the applicant, The Town of Lincoln requires a training course on the use of force, i.e. concealed carry course and/or basic pistol training.

While there cannot be any set formula or criteria to limit or restrict the Town of Lincoln's discretion to issue or deny a concealed weapon license, the Town will afford a hearing to each applicant before ruling on the application. The Town of Lincoln considers the following factors in assessing an applicant's good reason to fear an injury to his or her person or property or has any other proper reason for carrying a pistol or revolver, and that he or she is a suitable person to be so licensed.

- 1) Has the applicant demonstrated a good reason to fear an injury to his or her person or property or has any other proper reason for carrying a pistol or revolver?
- 2) Has the applicant demonstrated the skill, training, and ability to properly use a firearm in accordance with Rhode Island laws?
- 3) Has the applicant presented a plan to properly secure the firearm so that it does not fall into unauthorized hands?

- 4) How greatly will the possession of a firearm by the applicant increase the risk of harm to the applicant or to the public?
- 5) Has the applicant demonstrated that he or she will not use the firearm for an unlawful or improper purpose and that he or she has not used a firearm for an unlawful or improper purpose in the past?
- 6) Does past unlawful, dangerous, or violent conduct of the applicant justify denial of the license by the Town even if it is not sufficient to disqualify the applicant as a matter of law from possessing a firearm?
- 7) Has a protective order been issued relative to the applicant pursuant to Chapter 15-5, chapter 15-15, or Chapter 8-8.1 of the general laws?
- 8) Are there other factors deemed lawful and appropriate by the Town to demonstrate that the applicant is or is not a person suitable to possess a firearm in public?

After assessing the above factors, the Town shall grant or deny the concealed weapon permit, and in the case of a denial, shall state its reasons therefore in writing. In addition to these reasons, the Town will give consideration to those people who seek renewal of existing permits who have demonstrated through their actions and experience a level of responsibility commensurate with that expected of one who is privileged to carry a firearm in the public sector.

## **RESPONSIBILITIES**

Approved holders must maintain, use, and responsibly store their firearm or firearms. All permit holders are required to inform their respective city or town police departments, within 24 hours of becoming aware of the loss or of a weapon. If you do not report loss or theft in a timely manner, your permit may be suspended.

## **CONCLUSION**

This policy is meant as a general guideline to aid the public in understanding the Town of Lincoln's authority to carry out the requirements of the Rhode Island General Laws 11-47-11 and it shall be followed as a guideline in the assessment of applications for a pistol permit. This policy is not intended to and does not confer any rights on any person. As required by law, the Town of Lincoln shall retain the right to accept or reject any application for a pistol permit upon the applicant's demonstration of good reason to fear an injury to his or her person or property or has any other proper reason for carrying a pistol or revolver, and that he or she is a suitable person to be so licensed. This policy supersedes all prior policies.

Rev. December 2025.





REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, collection of information unless it displays a valid OMB number. We estimate that the use of this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release or 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, 15 CFR Parts 160 and 164; 5 L.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you are specially. Your disclosure of the information requested on this form is voluntary. However, if the information needed to locked rework's for release is not furnished completely, and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system or records notices identified as 24VA107 "Patient Medical Record - VA". 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice or Privacy Practices. VA may also use this information to identify Veterans and person 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)
Providence VA Medical Center (860 Chalkstone Avenue, Providence RI 02908)

LAST NAME- FIRST NAME- MIDDLE NAME DATE OF BIRTH (mm/dd-yyyy)

PATIENT'S MAILING ADDRESS (include City, State and Zip Code)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED
Lincoln Police Department (Detective Division)

PURPOSE (\$) OR NEED: Information is to be used by the requestor for:
TREATMENT BENEFITS LEGAL EMPLOYMENT (8) OTHER (Please specify) Background for Weapon

INFORMATION REQUESTED: Check applicable boxes and state the extent or nature of information to be provided:
HEALTH SUMMARY (Prior 2 years)
INPATIENT DISCHARGE SUMMARY (Date):
PROGRESS NOTES:
SPECIFIC CLINICS (Name & date range):
SPECIFIC PROVIDERS (Name & Office Range):
DATE RANGE:
OPERATIVE/CLINICAL PROCEDURES (Name & Date):
LAB RESULTS:
SPECIFIC TESTS (Name & Office):
DATE RANGE:
RADIOLOGY REPORTS (Name & Date):
LIST OF ACTIVE MEDICATIONS:
FLU VACCINATION (Dose, Last Number, Date & Location):

(8) OTHER describe: Psychological Testing/Eval. and/or Substance Abuse Treatment/Counseling





## Authorization for Release of Protected or Privileged Health Information

Please print all information clearly in order to process your request in a timely manner.

### A. Patient information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Medical Record #: \_\_\_\_\_  
 Address: Street: \_\_\_\_\_ Apt.: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Preferred Phone #: \_\_\_\_\_

### B. Permission to share I give my permission to share my protected health information.

#### Records from:

Name of Site Location: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_  
 Provider Name: \_\_\_\_\_

#### Purpose: (check the appropriate box)

- Medical Care
  - Insurance\*
  - Legal\*
  - Personal
  - School
  - Other\* (please specify) Background Investigation for Concealed Carry Permit
- \*Copying fees may apply

#### Send records to (Enter where you would like Mass General Brigham to send your information to):

Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below:

Name: Del. LT Brad Stewart/ Lincoln Police  
 Department Address: 100 Old River Road, Lincoln RI  
02865 bstewart@lincolnpoliceri.com  
 Telephone Number: (401) 333-8485

#### Send by:

- Mass General Brigham Patient Gateway (if available)
- Secure Email  
Email Address: bstewart@lincolnpoliceri.com
- Fax (provide fax number): \_\_\_\_\_
- Paper Copy via Mail

### C. Information to be released (please check all that apply, and MUST specify dates):

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Date(s) of Medical Record Abstract (e.g. History &amp; Physical, Operative Report, Consults, Test Reports, Discharge Summary) _____</li> <li><input type="checkbox"/> Date(s) of Clinic Visit Notes _____</li> <li><input type="checkbox"/> Date(s) of Discharge Summary _____</li> <li><input type="checkbox"/> Date(s) of Lab Reports _____</li> <li><input type="checkbox"/> Date(s) of Operative Reports _____</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Date(s) of Pathology Reports _____</li> <li><input type="checkbox"/> Date(s) of Radiation Reports _____</li> <li><input type="checkbox"/> Date(s) of Radiology Reports _____</li> <li><input type="checkbox"/> Date(s) of Photographs _____</li> <li><input type="checkbox"/> Date(s) of Billing Records _____</li> <li><input type="checkbox"/> Other (please specify below and include dates)</li> </ul> |
|---|--|



**Authorization for Release of Protected  
or Privileged Health Information**

**D. Please check YES to indicate if you give permission to release the following information if present in your record:**

- Yes HIV test results (Patient authorization required for each release request.)  
Specify dates \_\_\_\_\_
- Yes Genetic Screening test results  
Specify type of test \_\_\_\_\_
- Yes Substance Use Disorder Treatment 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 by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.) This consent may be revoked upon oral or written requests.
- Yes Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (I understand that my permission may not be required to release my mental health records for payment purposes)
- Yes Confidential Communications with a Licensed Social Worker
- Yes Details of Domestic Violence/ Intimate Partner Abuse Counseling
- Yes Details of Sexual Assault Counseling

**E. I understand and agree with that:**

Mass General Brigham cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Mass General Brigham may or may not protect this information once it has been released to the recipient

This authorization is voluntary

My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form

I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except:

- if Mass General Brigham has already processed the request (for example, once information is released, it will not be retrieved)
- if I signed this authorization as a condition of obtaining insurance. Other laws may provide the insurer with a right to contest a claim under the policy or the policy itself

This authorization will automatically expire 6 months from the date signed unless otherwise specified: \_\_\_\_\_

I understand that if Mass General Brigham maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in section C. Please include entity name, provider, and specific dates if known.

My questions about this authorization form have been answered

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name** \_\_\_\_\_

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

**Signature of Legal Representative: Date: Print Name:** \_\_\_\_\_

**Relationship of representative to patient:** \_\_\_\_\_

**For Internal Use Only:** Information Released/Reviewed By: Date: \_\_\_\_\_

Picked up by: \_\_\_\_\_ Pick-up Identification:  License  State ID  Passport  Other Photo ID \_\_\_\_\_





STATE OF RHODE ISLAND
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

1. (Print first name, last name & date of birth of the Individual for whom information is being requested)

Information to be obtained: ALL Applicable Records

\* 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.

2. My information is to be obtained from:

Eleanor Slater Hospital
(Name of Organization)
P.O. Box 8269
(Address)
Cranston RI 02920
(City/State/Zip)
Sharon Maynard (401) 462-2316 / Theresa Clark (401) 462-6790
(Contact Name and Telephone Number)

5. My information is to be released to:

Lincoln Police Department
(Name of Organization)
100 Old River Road
(Address)
Lincoln, RI, 02865
(City/State/Zip)
Det. LT Brad Stewart (401) 333-8485 bstewart@lincolnpolice.com
(Contact Name and Telephone Number)

6. This authorization is for information applicable to the time period specified below:

From: To:

Method of Communication:

Verbal Printed Materials

7. Background Investigation for Permit to Carry Concealable Weapon
(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 any time, 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 this authorization will remain in effect until I revoke it in writing, or upon my discharge from the hospital. (If not an inpatient, expires within 1 year of date of signature). I further understand that, pursuant to applicable law, certain information may be disclosed without my authorization 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:

**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". Indicate method of communication.
- Section 7. Indicate the reason why the information is needed.
- Section 8. Print the name and address of the individual at BHDDH responsible for receiving an individual's instructions to revoke the authorization.
- Section 9. Dated signature of the individual whose information is to be released. Authorization expires after patient is discharged from hospital or if not an inpatient, expires within 1 year of date of signature.
- 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.



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 understood 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 \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Maiden/Prior Names: \_\_\_\_\_ Current Phone #: \_\_\_\_\_  
Current Address: \_\_\_\_\_ Last 4 of SS#: \_\_\_\_\_

**To be released to or requested from:**

Self (address above)  
 \_\_\_\_\_ ( ) 333-8485 \_\_\_\_\_ 1 00 Old River Road \_\_\_\_\_

Agency/Organization Telephone Number Street Address  
\_\_\_\_\_  
( ) 334-4244 \_\_\_\_\_ Lincoln RI 02865  
Name / Attention to Fax Number State Zip Code  
City

Email: bstewart@lincolnpoliceri.com

Via (only when released to):  Mail  Fax  Pick-up  
 Verbal Exchange of Information ONLY

**I am requesting disclosure of my protected health information for the following purpose:**

Continuing Care  Disability Determination  Child Custody  Personal Use

Dates of Service Requested : a.all

I authorize the release of the following information **including** all records that include any substance use disorder and/or substance use disorder treatment records, or

I authorize the release of the following information **excluding** all records that include any substance use disorder and/or substance use disorder treatment records,

**Only the information and records indicated below (check all that apply and /or specific if "Other is checked):**

Continuity/Transition of Care  Physician Orders  
 Packet Psychiatric Evaluation  Lab/Diagnostic Reports  
 History and  HIV Test Results and AIDS Treatment  
 Physical  Records Other: Psychological testing/eval. or counseling  
 Discharge Summary  
 Progress Notes

This authorization will expire on \_\_\_/\_\_\_/20\_\_\_. (If not indicated, authorization will expire one year from signature date)

This form must be completed in full before signing:

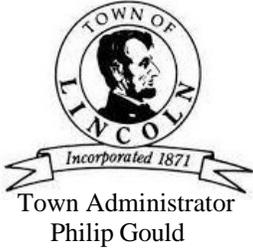
Patient's signature (required for ages 18 and older) \_\_\_\_\_ Parent/Legal Guardian signature (if applicable) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Witness signature/Credentials \_\_\_\_\_ Date Signed \_\_\_\_\_

This authorization is intended to allow Fuller Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. 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 there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

Revocation Signature \_\_\_\_\_ Date/Time \_\_\_\_\_



# Lincoln Police Department

100 Old River Road  
Lincoln, RI 02865  
(401) 333-1111  
*A State Accredited Agency*



Chief of Police  
Dennis Fleming

## Authorization for Release of Personal Information

I, \_\_\_\_\_ do hereby authorize a review of and full disclosure of all records, or any part thereof, concerning myself, by and to duly authorized agent of the Lincoln Police Department, whether the said records are of a public, private, or confidential nature.

The intent of the authorization is to give my consent for full and complete disclosure of the records of medical and psychiatric treatment and/or consultation, including hospitals, clinics, private practitioners, and the U.S. Veteran's Administration; public utility companies; employment and pre-employment records, including background reports, efficiency ratings, complaints or grievances filed by or against me, records of complaint, arrest, trial and/or convictions for alleged or actual violations of law, including criminal and/or traffic records; records of complaints of a civil nature made by recollections of attorneys at law, or of other counsel, whether representing me or another person in any case in which I presently have, or have had and interest.

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 for the Lincoln Police Department to consider determining my suitability to carry a concealed weapon.

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, upon this release authorization will be considered in determining my suitability for carrying a concealed weapon by the Lincoln 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.

A photocopy or a facsimile (FAX) of this release form will be valid as an original hereof, even though the said photocopy does not contain an original writing of my signature.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN# \_\_\_\_\_

Witness : \_\_\_\_\_