

AUTHORIZATION FOR THE RELEASE OF INFORMATION

By signing this form, I authorize Riverside Medical Group to release the medical records of:

Patient's full name: _____ Date of Birth _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: () _____

Release records to:

Recipient(s) _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: () _____

Provider or Clinic Name: _____

Information to be released (please ✓ checkmark):

- Medical Record for past 3 years
- Date(s) of Service: _____ to _____
- Entire Medical Record (including billing information, radiology studies, and records from prior providers)
- Medical History, Evaluation Records Radiology Reports Laboratory Results
- Cardiology Results Immunizations Prescription Data
- Consultation Documentation Surgical Reports Summary of Record
- Other (specify): _____

I understand that the records released may include sensitive information including mental health, substance use disorder, HIV/AIDS, communicable and sexually transmitted disease and genetic testing.

Reason for the Release of Information:

- At the request of the individual (Patient)
- Other (specify): _____

Revocation: I have the right to revoke this authorization at any time by writing to Riverside. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Redisclosure: I understand that the information released according to this authorization may be subject to redisclosure by the recipient(s) and no longer protected under HIPAA federal law.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Signature of Patient (*or representative authorized by law): _____

Print Name: _____

Relationship (if you are not the patient): _____ **Today's Date:** _____

Expiration Date/Event: _____ (if none specified, the Authorization remains valid for one year from the date of signature).

*Riverside may require court documentation verifying your authority to sign on behalf of the patient.

Office use only: Date received: _____ / _____ / _____ Received by (Print Name/Initial): _____
Ticket: _____ Date completed: _____ / _____ / _____ <input type="checkbox"/> Faxed <input type="checkbox"/> Mailed <input type="checkbox"/> Emailed <input type="checkbox"/> Picked up