RIVERSIDE

Clear Form

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

______________________________ ______________ (______) ________-________
(Patient Full Legal Name Including Prior Names) (Date of Birth) (Day Phone #)

Address: ______________________ City: ______________ State: _______Zip:_________

I, authorize Riverside Health System to release the health information from the Riverside location listed below:

From Location(s) of Service ______________________(Indicate Type of Practice or Riverside Facility Location)

For Date(s) of Service: ______________________________

To Disclose the Following Information:

☐ Clinical Abstract of Record ☐ X-ray or Imaging Report(s) ☐ Billing Records ☐ ER Record
☐ Laboratory Results ☐ Immunization Record ☐ Other: ______________________

Person/Facility to Receive Information: ______________________________

Address:______________________________ Phone/Fax ______________

Disclosure Format (paper is default if not marked): ☐ US Mail ☐ Radiology Film/CD ☐ Email ☐ Site Pick-up ☐ Riverside MyChart

Email Address for record delivery

Purpose of Disclosure:

☐ Continuing Care ☐ Insurance / Disability Determination ☐ Legal ☐ Other (Please specify):

Authorization to Release Information:

1. I understand that I am giving my permission to disclose confidential health care records relating to, if applicable, sexually transmitted diseases, including but not limited to AIDS or HIV, behavioral or mental health services, treatment for alcohol, drug abuse and genetic information.
2. I understand the following: This authorization is voluntary and not a condition of treatment. Once my health information is disclosed to others, it may be redisclosed by them to others that are not subject to the privacy regulations. I have the right to revoke this authorization at any time. I must do so in writing and present my written revocation to Riverside. Any revocation does not apply to information that has already been released. The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3. This authorization will expire upon delivery of above requested records.
4. I understand that copying charges will be applied, according to the hospital policy.

Signature of Patient or Legal Representative

______________________________Date ______________ Time__________

If signed by legal representative, relationship to patient: ______________________________

** Not applicable for Lifelong Health*

DEPARTMENT USE ONLY

Processed By: ______________________Date__________Time______Identity Verified ☐ Signature Verified

(replaces RRCC0385, RBHC0012B, RHS0242)

(1000) RRMC6724 R26 9/2022