RIVERSIDE

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: (1)_____(2)_____(3)_____(4)_____

To Disclose the Following Information:

☐ Clinical Abstract of Record including:_____ ☐ X-ray or Imaging Report(s) ☐ Billing Records

☐ ER Record ☐ Laboratory Results ☐ Immunization Record ☐ Other: _____

Person/Facility to Receive Information: _____

Address:_____(email if applicable)_____

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

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, unless indicated below, relating to, if applicable, sexually transmitted disease (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 at the time of my death, unless I indicate below an earlier date or request a revocation at a later date. If you want an earlier date for expiration of this authorization, insert date of expiration here (_____.)
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)