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 (*Not applicable for Lifelong Health)*)

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 as well as reproductive treatment. This Authorization does not apply to Substance Abuse Disorder or treatment records protected by federal law 42 CFR Part 2 .
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 unless I request a different expiration date indicated as follows: _____
4. I understand that copying charges will be applied, according to Riverside policy.

Note: If records are for a patient ages 13-17, both the minor patient and the parent/legal guardian must sign this form, unless the minor patient has special needs.

_____ Date _____ Time _____
Signature of Adult Patient or Minor Patient 13- 17 *years of age*

_____ Date _____ Time _____
Signature of Parent/Legal Guardian of Minor Patient 13- 17 *years of age*
or Legal Representative of Adult Patient

Relationship to patient: _____

DEPARTMENT USE ONLY

Processed By: _____ Date _____ Time _____ Identity Verified ☐ Signature Verified

(replaces RRCC0385, RBHC0012B, RHS0242)

(1000) RRMC6724 R27 4/2023