Riverside MEDICAL GROUP
*Your family's complete medical home.*

# 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)*
- ☐ Behavioral/Mental Health Records

| | | |
|---|---|---|
| ☐ 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:_____/_____/_____ ❑Faxed ❑Mailed ❑Emailed ❑Picked up