Riverside MEDICAL GROUP

Section 1: Requestor information & contact details

I am submitting this request for my: ☐ Self ☐ Someone else (describe relationship) ☐ Minor child ______________________

Preferred contact for questions:

( )	( )	
Home Phone	*Cell Phone*	*Email Address*

Section 2: Patient whose information is being requested

First Name	*Middle Initial*	*Last Name*

	( )
Date of Birth	*Phone Number*

Address

City	*State*	*ZIP Code*

Section 3: Legal representative (Required if requestor is not the patient)

		( )
First Name	*Last Name*	*Phone*

Relationship to patient

☐ Parent or legal guardian (describe relationship) ______________________

☐ *Someone else (describe relationship) ______________________

**Attach supporting documentation with your request form*

Section 4: Type of PHI requested

I would like to request the following type(s) of information (*Check all that apply*):
Some information, such as recordings of phone calls maintained for quality assurance purposes or PHI not used to make decisions about individuals, is not contained within the DRS and may not be provided.

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): ____

Section 5: Recipient and format of PHI

Recipient of the PHI (*Select only one option*)

☐ **Option 1:** Myself (the patient)

☐ **Option 2:** Someone else

Recipient First Name	*Recipient Last Name*	*Relationship*

Format of the PHI (*how and where should we send the records*)

☐ **Option 1:** PDF sent by secure email to ______________________
Email Address

☐ **Option 2:** Paper copy sent in the mail to the address below (*complete if different from Section 2*)

☐ **Option 3:** Other readily producible electronic format sent to the address below (*complete if different from Section 2*). Please describe:

____

____
Address

City	*State*	*ZIP Code*

Section 6: Patient or Legal representative's signature

I authorize the release of my PHI as identified above. I understand that this request does not apply to certain health information, including: (1) information that is not received or maintained by Optum, (2) psychotherapy notes, (3) information compiled in reasonable anticipation of or for litigation, and (4) other information not available for access under HIPAA.

Patient or legal representative's signature ***Date** (MM/DD/YYYY)*

Return the completed form via

Email: medicalrecords@riversidemedgroup.com

or

Fax: 551-257-7595

or

Mail: Riverside Medical Group
HIM Department, 1 Harmon Plaza at 4th Floor Secaucus, NJ 07094