



**Authorization for Disclosure of Health Information
Riverside Medical Clinic, Health Information Management Department**

7117 Brockton Avenue, Riverside , CA 92506

Phone: 951-782-6272 or 951-782-3733 • Fax: 951-784-6481

Email: himdepartment@rmcps.com

Legendary Care™

Delivery Instructions	<input type="checkbox"/> Mail records directly to Riverside Medical Clinic <input type="checkbox"/> Fax: 951-784-6481 <input type="checkbox"/> Electronic Mail: himdepartment@rmcps.com
Notice of Rights	<p>I understand that:</p> <ol style="list-style-type: none"> 1. If I refuse to sign this authorization, my refusal will not affect my ability to obtain treatment. 2. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. 3. I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered to: Organization listed in the "Release To" section above. 4. If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation. 5. I have a right to receive a copy of this authorization. 6. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
Expiration	Without my written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 30 days from the date hereof, unless otherwise specified: _____
Signature	Signature: _____ Date: _____ (Patient or Legal Representative) Legal Representative Relationship: _____ Witness: _____