Legendary Care™

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

7117 Brockton Avenue, Riverside , CA 92506
Phone: 951-782-6272 or 91-782-3733 • Fax: 951-784-6481
Email: himdepartment@rmcps.com

Authorization for: ☐ Copies of Medical Record ☐ Inspect or Review Medical Record

Patient Information

Patient Name:______________________________ MRN:______________
(Last Name) (First Name) (office use only)

Other Names Used:______________________________

Address:______________________ City/State/Zip:______________________

Date of Birth:______________________ Phone:______________________

Release to

I authorize Riverside Medical Clinic to Release Medical Records to: (Required Information: If not completed, request will be returned)

Person/Organization:______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone:________________ Fax:________________

Purpose

For the Following:
- ☐ Continuing Care
- ☐ VA/Military
- ☐ Personal Use
- ☐ Other:__________
____
____

Information to Release

Treatment Dates:______________________
(If no date is stated, last 2 years will be provided)

- ☐ Visit/Consultation Notes
- ☐ Procedure Reports
- ☐ Immunization Report
- ☐ Laboratory Test Results
- ☐ Imaging Reports
- ☐ Imaging – X-Ray/Other Imaging Studies on CD
- ☐ Billing – Patient Billing Records
- ☐ Other (Please Specify)______________________________
____
- ☐ EKG
- ☐ Urgent Care
- ☐ Pathology Reports

State/Federal Laws require specific authorization to release the following types of information **(initial):**

_____ Mental Health Treatment _____ Alcohol/Drug Treatment

_____ HIV Test Results _____ Genetic Testing

Fees

Based on California Evidence Code Sections 1560-1567. Fees may be charged for medical record copies.

Delivery Instructions

- ☐ Mail records directly to person or organization specified
- ☐ Call Requester when records are ready for pick up

I authorize ______________________________to pick up my medical record copies.

Relationship to patient:______________________________

- ☐ Other ______________________________

Complete Backside

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Section	Content
Notice of Rights	**I understand that:** 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: Riverside Medical Clinic, 7117 Brockton Ave., Riverside CA 92506 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: ____