Authorization for Disclosure of Health Information

Riverside Medical Clinic
Medical Record Department
7117 Brockton Avenue, Riverside CA 92506
Phone: 951-782-6272 Fax: 951-784-6481

RIVERSIDE MEDICAL CLINIC
Legendary Care™

Authorization for: ❒ Copies of Medical Records to be sent to Riverside Medical Clinic

Patient Information

Patient Name:______________________________ MRN:___________
(Last Name) (First Name)
Other Names Used:____
Date of Birth:_______________________________ Phone:__________
Address:____

Release To:

I authorize:
Organization:___________________________

Address:__________________________________

City/State/Zip:______________________________

To release my medical records to:
Riverside Medical Clinic
Medical Record Department
7117 Brockton Avenue
Riverside CA 92506

Purpose

For the Following:
___Continuing Care
___Other:_______
____

Information to Release

Treatment Dates:___________________________

___Visit/Consultation Notes ___EKG
___Procedure Reports ___Urgent Care
___Immunization Report ___Pathology Reports
___Laboratory Test Results
___Imaging Reports
___Imaging –XRay/Other Imaging Studies on CD
___Hospital Records
___Other(Please Specify)________________________

Provider Name(s)______________________________

State/Federal Laws require specific authorization to release the following types of information:
___Mental Health
___HIV/AIDS Test Results ___Genetic Testing Info.

Fees

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

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Delivery Instructions	❒ Mail records directly to Riverside Medical Clinic ❒ Call Requester when records are ready for pick up I authorize ________________________to pick up my medical record copies. Relationship to patient:____ ❒ Other:____
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: 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 180 days from the date hereof, unless otherwise specified: ______________________________
Signature	Signature:_______________________________(Patient or Legal Representative) Legal Representative Relationship:_____________________________________ Date:_________________ Witness: ____________________________________