AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

RECEIVED NOTICE OF PRIVACY PRACTICES ☐ YES ☐ NO

Section A: This section must be completed for all Authorizations - I authorize Riverside Community Hospital to release information.

Patient/Plan Member Name:	Birth Date:	Social Security No. *(optional):*
Provider/Health Plan's Name:	Recipient's Name:	
Provider/Health Plan's Address:	Phone: Fax:	
	Address:	
	City: State: Zip:	

This authorization will expire on the following: (Fill in the Date or Event but not both.)
Date: Event:

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative information ☐ Cath lab ☐ Special Test/Therapy ☐ Rhythm strips ☐ Nursing information ☐ Transfer forms ☐ ER information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill ☐ UB-92 ☐ Other: ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment. payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it. **I want a copy of this form:** ☐ Yes ☐ No

Section B: Is the request of PHI for the purpose of marketing? ☐ Yes ☐ No
If yes, the health plan or health care provider must complete section B, otherwise skip to section C.

Will the recipient receive financial or in-kind compensation in exchange for disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures ID Verified: ☐ Yes ☐ No

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member:

*** These boxes must be completed**

Please contact facility Privacy Officer, ext. 3526, or HIM/Medical Records, ext. 3165 if you have any questions.

Revised 3/2001

MEDICAL RECORDS FAX: 909-788-3175

Authorized Agent:
Knox Attorney Service, Inc./ Knox Services LLC.