RIVERSIDE CENTER FOR
BEHAVIORAL MEDICINE
5900 Brockton Avenue
Riverside, CA 92506
(951)275-8400 FAX (951)786-0293

Release Processed
By: _____
Date: _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL / PSYCHIATRIC / DRUG-ALCOHOL ABUSE INFORMATION

Patient Name: _____ DOB: _____

Information to be released from:

Name/Agency Riverside Center for Behavioral Medicine

Address/Phone/Fax#: 5900 Brockton Avenue Riverside, Ca. 92506 (951)275-8400 (951)786-0293 FAX

Information to be released to:

Name/Agency _____

Address/Phone/Fax#: _____

Purpose for release:

_____ Continued Care by receiving facility/doctor/therapist
_____ Aid by the above named agency
_____ Arrange for Residential Treatment
_____ Claims settlement with insurance company
_____ Legal proceeding or advice
_____ Other: _____

Information to be released:

_____ Discharge Summary
_____ History & Physical Exam
_____ Psych. Evaluation/MSE
_____ Psychological Test Results
_____ Consultation
_____ Dates of Hospitalizations Only
_____ Treatment Plan
_____ Progress Notes
_____ Physician's Orders
_____ Diagnoses (psychiatric)
_____ Diagnoses (medical)
_____ Verbal info: Dr. name, name of facility, admit and D/C dates for insurance billing
_____ Psychological History
_____ Lab/X-Ray Reports
_____ Nursing Notes
_____ Medications
_____ EKG

Other (specify): _____

I am aware of the provisions of existing State and Federal Statutes, Rules and Regulations as outlined on the reverse side of this form, which provide for my right to confidentiality of the information in these records.

I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization before any records can be released, and that I may refuse to sign, but in that event the records cannot and will not be released.

I further release my attending physician, the House Supervisor and employees of the House Supervisor from any liability arising from the release of information to the person(s)/agency designated above.

I understand that I have the following rights with respect to this Authorization:

1. The recipient of the protected health information may not further disclose the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.
2. I may not be required to sign this authorization as a condition to obtaining treatment or payment or my eligibility for benefits.
3. Riverside Center for Behavioral Medicine will provide me with a copy of this Authorization.
4. I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocations to Riverside Center for Behavioral Medicine at 5900 Brockton Ave., Riverside, CA 92506. Such revocation will be effective upon receipt, except to the extent that the recipient has taken action in reliance on this Authorization.
5. A copy is as valid as an original.
6. I understand that I am entitled to notice if Riverside Center for Behavioral Medicine will use or disclose the protected health information for marketing and receive payment for the use or disclosure of my protected health information.

   Riverside Center for Behavioral Medicine ☐ will ☐ will not receive compensation for the use or disclosure of my protected health information.

_____ _____
Signature of Patient/Personal Representative/Relationship Print Name

_____ This Authorization will expire on: _____
Date of Request Expiration date not to exceed one (1) year

The undersigned practitioner who is primarily responsible for the treatment of the patient, will hereby Approves ☐ Disapproves ☐ the release of records to the patient, the patient's personal representative, or for purposes of hand carrying records to the party specified above. If the disclosure is disapproved, please give the reason or note any restrictions of the release of records.

_____
Print Clinicians Name Clinicians Signature Date

RC106 White – Medical Records Canary – Business Office Pink – Patient