# 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's/Health Insurance:** | **Recipient's Name:** * | |
| **Provider's/Health Insurance Address:** | **Phone:** * | **Fax:** |
| | **Address:** * | |
| | **City:** * | **State:** * **Zip:** * |

This authorization will expire on the following: (Fill in the Date or the 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<br>❑ Admission form<br>❑ Dictation reports<br>❑ Physician orders<br>❑ Intake/Output<br>❑ Clinical Test<br>❑ Medication Sheets | | ❑ Operative Information<br>❑ Cath lab<br>❑ Special test/therapy<br>❑ EKG<br>❑ Nursing Notes<br>❑ Transfer forms<br>❑ ED Reports | | ❑ Labor/delivery sum.<br>❑ Itemized bill:<br>❑ UB-92: _____<br>❑ Other: _____<br>❑ 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 affect 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 redisclosed.
5. I understand that I may see and obtain a copy 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** *

***These Boxes Must Be Completed**



**Continued on Reverse Side** ➪

**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-king compensation in exchange for using or disclosing this information? ❑ Yes ❑ No If yes, describe:

**Section C: Signatures**

I have read the above and authorized the disclosure of the protected health information as stated.
ID Verified ❑ Yes ❑ No

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

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

RIVERSIDE Community Hospital

Date: _____

**We are unable to process your request for protected health information (PHI) due to the reason(s) indicated below:**

***Authorizations must:***

- ❑ Be in writing and in plain language*
- ❑ Describe the requested PHI in detail*
- ❑ State why the PHI is being requested*
- ❑ Identify who's being authorized to disclose the requested PHI*
- ❑ State to whom our organization may make the requested disclosure*
- ❑ State an expiration date or expiration event that hasn't yet passed*
- ❑ State the patient's right to revoke the authorization and either tell the patient how to do it or refer to the Outsider's Notice of Privacy Practices Regarding Revocation*
- ❑ State that once the requested PHI is disclosed, the PHI'S recipient may redisclose it, and the Privacy regulations may no longer protect it*
- ❑ Tell the patient whether the HIPAA Privacy Regulations allow the outsider to condition treatment, payment, enrollment, or eligibility for benefits on getting the authorization*
- ❑ Either be signed and dated by the patient or signed and dated by his/her personal representative and describe the representative's authority to act for him/her*
- ❑ Be combined with other authorizations, but not with any other document*

**** As of April 14, 2003, all Federal requirements under the Health Insurance Portability and Accountability Act.***

- ❑ Need additional information: ❑ Date of Birth ❑ Social Security Number ❑ Other: _____
- ❑ Illegible
- ❑ Records contain special & protected information requiring a more specific authorization
- ❑ Authorized individual must complete and sign the authorization
- ❑ We have information that indicates records may be located at: _____
- ❑ Other _____

***Please complete the authorization on the back of this form and forward it to the RCH HIM/Medical Records Department Reception Desk. If you need assistance please call (951) 788-3165. Thank you.***