RIVERSIDE PSYCHIATRIC MEDICAL GROUP 5887 BROCKTON AVENUE, SUITE A • RIVERSIDE, CALIFORNIA 92506 • (909) 275-8500

AUTHORIZATION FOR THE RELEASE OF MEDICAL/PSYCHIATRIC/CHEMICAL DEPENDENCY INFORMATION

This authorization for use or disclosure of medical/psychiatric/chemical dependency information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PATIENT NAME: _____ **DOB:** _____

I hereby authorize:

Name/Agency: Riverside Psychiatric Medical Group

Address: 5887 Brockton Ave. Ste A. Riverside CA 92506

To release information to:

Name/Agency: _____

Address: _____

PURPOSE FOR RELEASE:

- ☐ Continued care by receiving facility/doctor/therapist
- ☐ Claims settlement with insurance company
- ☐ Aid by the above named agency
- ☐ Legal proceeding or advice
- ☐ Disability claim
- ☐ Other: _____

INFORMATION TO BE RELEASED:

- ☐ Psychological/Psychiatric Evaluation
- ☐ Psychological Test Results
- ☐ Psychoeducational Test Results
- ☐ Treatment Plan
- ☐ Progress Notes
- ☐ Diagnoses (psychiatric)
- ☐ Diagnoses (medical)
- ☐ Psychological History
- ☐ Lab/X-Ray Reports
- ☐ Other: _____ (PLEASE SPECIFY)

This authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires within one (1) year from the date of signing.

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 understand that the reviewing agency or person may not further disclose this confidential information.

_____ DATE

_____ DATE

_____ PARENT/LEGAL GUARDIAN/CONSERVATOR

_____ PATIENT/CONSERVATOR/POWER OF ATTORNEY

_____ RELATIONSHIP TO PATIENT

_____ SIGNATURE OF WITNESS