RIVERWOOD HEALTHCARE CENTER
AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

1. **Patient** Information	NAME_____ DATE OF BIRTH_____ Address:_____ City:_____ State:_____ Zip:_____ Phone:_____
2. Release Information From: (***Who*** has the information you want released?)	NAME/ORGANIZATION_____ Phone_____ Address_____ Fax_____ City_____ State_____ Zip_____
3. Release Information To: (***Where*** do you want the information sent?)	NAME/ORGANIZATION_____ Phone_____ Address_____ Fax_____ City_____ State_____ Zip_____
4. Purpose of Release: (***Why*** is it needed?)	☐ Continuing Care ☐ Workers' Compensation ☐ Legal ☐ Personal Use ☐ Insurance ☐ Disability Determination ☐ Other_____
5. **What** are the approximate dates of information you want released? ***What*** do you want released? Choose **Routine** for items a healthcare provider typically needs, *or* select individual records.	**Service Dates Between** _____ to _____ **Information to be Released:** ☐ **Routine Record Sets** (Notes, Labs, Rad, Procedures, Emergency, Consultation, History & Physical) ☐ Physician Office Notes ☐ Operative/Procedure Notes ☐ Cardiology/EKG ☐ Radiology/XRay/MRI ☐ Psychological Testing/Mental Health ☐ Chemical Dependency/ Substance Abuse ☐ Lab/Path Reports ☐ HIV/AIDS Testing ☐ Medical Imaging Films
	All information regarding chemical dependency or behavioral health will be released **unless you restrict** by initialing: _____Do not release chemical dependency information _____Do not release behavioral health information

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires once the above stated purpose is fulfilled or one year, whichever comes first.

Patient/ Legal Guardian Signature:_____ Date: _____

Authority to act on behalf of patient (attach document) _____

Riverwood Health Information FAX number: 218-927-5319