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RIVERSIDE MEDICAL CENTER

CONSENT TO RELEASE MEDICAL RECORDS

This consent is valid for three (3) months after the date of patient's/representative's signature

Patient Name _____ Birthdate _____

Last 4 digits SSN _____ MRUN _____

I, _____ , agree that Riverside Medical Center may allow
(name of patient or representative - please print)

Recipient _____

Full Street Address _____ Phone _____

City, State, Zip Code _____ Fax _____

to review and/or receive copies of this patient's medical record regarding care given from:

(date)_____, to (date)_____, specifically (please check)

- ☐ Admission Record
- ☐ Discharge Summary
- ☐ History and Physical Examination
- ☐ Admission Evaluation (Mental Health)
- ☐ Consultation Reports
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Emergency Dept. Records
- ☐ Physician Progress Notes
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Cardiology Reports (e.g., EKG, Echo, Stress Test)
- ☐ Neurology Reports (e.g., EEG, EMG)
- ☐ Rehab Services Notes (e.g., PT, OT, Speech Therapy)
- ☐ List of visit dates
- ☐ Other_____

I fully understand that this release will include information relating to the testing, examination, diagnosis, treatment and/or referral regarding the conditions listed below unless initialed by the signing party(ies):

_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency) infection
_____ Alcohol and/or drug use or dependence
_____ Mental health condition or developmental disability
_____ Sexually-transmitted disease

Purpose of Release _____

I understand that I may inspect and have copies of the information I am releasing (according to Riverside policy) and that I may revoke this consent at any time (except to the extent that Riverside Medical Center has already acted on this consent to release medical records) by notifying the Medical Records Department at Riverside Medical Center in writing that I am revoking this consent.

I understand that the information identified above cannot be released unless I sign and date this consent form and that the stated purpose of the release may be in jeopardy if I do not allow the information to be released. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on signing this consent.

I release Riverside Medical Center from all legal responsibility and liability for the information released according to the terms of this written consent. I understand that there is the potential for this protected health information to be re-disclosed by the recipient and thus no longer protected under the HIPAA privacy rule.

SIGNED _____ DATE _____

If you are not the patient, specify your relationship to the patient and the reason you are signing this consent for him:

RELATIONSHIP & REASON _____

Second signature (if required):

SIGNED _____ DATE _____

WITNESS _____ DATE _____

RELEASED BY _____ DATE _____