

## AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Name of Patient: \_\_\_\_\_ Chart #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I authorize:

- RiverView Health
- RiverView Care Center
- RiverView Clinics

To release to/obtain from: (circle one)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED (specify dates for each, unless "entire medical record" is selected)

- |   |  |
|---|--|
| <input type="checkbox"/> History & Physical _____                 | <input type="checkbox"/> Lab Reports _____                         |
| <input type="checkbox"/> Hospital Discharge Summary _____         | <input type="checkbox"/> X-ray reports _____                       |
| <input type="checkbox"/> Operative Report _____                   | <input type="checkbox"/> X-ray films _____                         |
| <input type="checkbox"/> Progress Notes _____                     | <input type="checkbox"/> Entire Medical Record for all dates _____ |
| <input type="checkbox"/> Pathology Report _____                   | <input type="checkbox"/> Emergency Room Record _____               |
| <input type="checkbox"/> Billing information _____                | <input type="checkbox"/> Other (please specify) _____              |
| <input type="checkbox"/> HIV (AIDS or Communicable Disease) _____ |  |

I authorize verbal and/or written exchange about my medical information

### PURPOSE OF THE USE AND DISCLOSURE

- |  |  |
|--|--|
| <input type="checkbox"/> Further Treatment (Date of Appointment _____) | <input type="checkbox"/> Personal Records            |
| <input type="checkbox"/> Insurance Application                         | <input type="checkbox"/> Education                   |
| <input type="checkbox"/> Disability Determination                      | <input type="checkbox"/> Payment of Insurance Claims |
| <input type="checkbox"/> Vocational Rehabilitation Evaluation          | <input type="checkbox"/> Legal                       |
| <input type="checkbox"/> At my request                                 |  |
| <input type="checkbox"/> Other: _____                                  |  |

I understand that my records may contain information regarding drug, alcohol, psychological or psychiatric conditions and communicable diseases are protected by Federal Law (42CFR Part 2) and/or HIPPA (45FR) and cannot be disclosed without this written consent unless otherwise provided in the federal and state regulations.

I authorize the use and disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire on: \_\_\_\_\_ (specify date or event) or, if no date or event is specified, 12 months from the date of signing.

A photocopy or fax of this authorization will be treated in the same manner as the original.

\_\_\_\_\_  
Signature of Patient/Guardian/Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
(If not patient, state authority/relationship)

\_\_\_\_\_  
Reason patient unable to sign