Riverview Psychiatric Medicine, PC

Phone (845) 471-1807 Fax: (845) 471-1815

Authorization to Release Medical Records:

PATIENT INFORMATION:

Name (Print): DOB SSN

____ ____________ ______________________

INFORMATION TO BE RELEASED FROM:

Name of Facility or Provider

____

Address: City: State: Zip:

____ _________________________ ______ ________

INFORMATION TO BE RELEASED TO:

Name of Facility or Provider

____

Address: City: State: Zip:

____ _________________________ ______ ________

INFORMATION TO BE RELEASED: (CHECK ALL THAT APPLY)

_______ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)

_______ All medical records

_______ Specific information (please specify):

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE:

_____ Attorney _____ Insurance _____ Doctor _____ Personal

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits. I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

Signature: ______________________________________ Date:____________________________

(Patient, guardian, or Authorized representative)