riverside
women's care

|Authorization for Release of Protected Information

Name: _____ Date of Birth: _____

Riverside Women's Care, maintains a medical record containing personal and medical information about you. This information has been compiled from information provided by you, other healthcare providers, and treatment information from your visits to the office. We will release information regarding appointments, test results or follow-up telephone messages on your voicemail or with your family members at your residence *unless you sign here that you do not authorize this*.

_____ (Signature).

Authorization for Release of Protected Health Information

I authorize **Riverside Women's Care**, to release medical information concerning my appointments, treatment, medications and examinations and to discuss financial information to the following person(s) /entity:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

_____

If someone will be picking up your prescriptions for you, their information must be written above.

I understand that the release or transfer of information to any person or entity not specified above is prohibited. If there are any changes in the persons or entities that I allow my Protected Health Information to be released to, I will complete and sign a new form. I understand that *Riverside Women's Care* cannot accept authorizations by telephone due to the nature of the information contained in my medical record. I understand that *Riverside Women's Care* is authorized to release protected health information about myself to other healthcare providers and insurance companies as explained in the "Notice of Privacy Practices."

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect a copy of the Protected Health Information to be disclosed. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon my signing this document. This authorization shall remain in effect until revoked in writing by the patient.

_____ _____

Signature of Patient or Representative Date

_____

Description of Personal Representative's Authority (attach Legal Documentation)