COUNTY OF RIVERSIDE COMMUNITY HEALTH AGENCY, DEPARTMENT OF PUBLIC HEALTH
AUTHORIZATION FOR RELEASE OF INFORMATION FROM THE MEDICAL RECORD

PATIENTS LAST NAME	FIRST NAME	MIDDLE NAME	BIRTHDATE
STREET	CITY	ZIP CODE	TELEPHONE
CLINIC SITE			APPROXIMATE DATE OF TREATMENT

I, the undersigned, hereby authorize: (Provider/Organization with the records)

NAME

STREET ADDRESS

CITY STATE ZIP CODE

to provide to: (Provider/Organization to receive the medical information)

NAME

ATTENTION

STREET ADDRESS

CITY STATE ZIP CODE

access to my medical records for the purpose of: _____

Medical information to be disclosed:

_____	Laboratory reports	_____	Progress notes
_____	X-ray reports	_____	All medical records
_____	EKG	_____	Other
_____	HIV, AIDS, Psychosocial & Drug & Alcohol History		

Restrictions:
I understand that this authorization is voluntary. Treatment, payment or eligibility for my benefits will not be affected if I do not sign this authorization. I understand that the physician or health care provider releasing my medical information and PHI pursuant to this request to the person designated on this form may not be held liable for the mis-use of such information when received by the person designated on this form.
I understand that the person designated on this form to receive my information may not further use or disclose my medical information or PHI unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Additional Copy:
I further understand that I have a right to receive a copy of this authorization upon my request.
Copy requested and received: [ ] Yes [ ] No Initial _____

Unless otherwise revoked in writing, this authorization expires in 3 months. You may revoke this authorization in writing at any time by sending a notice to the Custodian of Records.

SIGNATURE PATIENT PARENT - LEGAL GUARDIAN OR PERSONAL REPRESENTATIVE (PLEASE CIRCLE) DATE

SIGNATURE WITNESS DATE