AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

NOTICE TO PATIENTS: COPIES OF PAPER MEDICAL RECORDS OVER 10 PAGES ARE SUBJECT TO A FLAT FEE OF $15.00 PLUS .25 CENTS PER PAGE AFTER THE FIRST 10 PAGES OR PUBLISHED ON A CD FOR FLAT FEE OF $15.00. PRE-PAYMENT IS REQUIRED. Thank you

1. I hereby authorize **Riverside Medical Group** to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. Patient Information:

Name: ____ D/O/B: ____________________

Address: ______________________________________ S.S.#: ______ - ______ - ______

City/State/Zip: ________________________________

Telephone #: (Home) ____________________ (Work) ____________________

3. Information to be disclosed to:

Name: ____

Address: ____

City/State/Zip: ____

4. Information to be released:

- □ specific date of visit / information ____________________
- □ record date range from ______________ to ______________
- □ other (please describe) ____________________________
- □ last 10 pages only (no charge) □ verbal communication
- □ all records dated from 01/2019-present

In order to expedite your request for medical records Riverside Medical Group has on site access to patient medical records dating from the present back to 12/2008, and will routinely provide records for treatment you received within this date span.

Please keep in mind that your most important health information is usually included in the last two years of your medical record. However, we will be happy to provide you with copies of older records if you require them. For these older records please allow additional time to process your request so that we may retrieve those records from our off site record storage facility.

5. The above information is to be used for the following purpose:

_____Medical Treatment _____Transfer to new doctor _____ Personal use _____ Other______________

6. I understand that I may refuse to sign this form, and that should I refuse to do so, it will not affect my health care, the payment of my health care, or my eligibility for benefits. I understand that I may revoke this authorization at any time by requesting such of the above referenced hospital/physician/facility in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

7. Expiration: This authorization will expire automatically in six months or on the following date (no later than one year from now) or event:____

8. ______________ ______________________________ ______________________________
Date Signature of Patient/ Legal Representative Authority or Relationship of Representative

9. Massachusetts state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. By my signature below, I authorize release of the following medical information that may be held by above named facility: information pertaining to my HIV status, records of mental health care and treatment, records of abuse, records of care and treatment for sexually transmitted disease, and records of substance abuse care and treatment.

______________ ______________________________ ______________________________
Date Signature of Patient/Legal Representative Authority or Relationship of Representative