HIPPA AUTHORIZATION/RELEASE OF MEDICAL INFORMATION

If an emergency situation arises or you anticipate the need for anyone else to have access to protected health information, please complete the information below.

I, the undersigned patient and/or responsible party hereby authorize Riverside Family Medicine, it's physicians, agents, employees, or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc to the following :

NAME:_____RELATIONSHIP:_____Phone #:_____

NAME:_____RELATIONSHIP:_____Phone#:_____

NAME:_____RELATIONSHIP:_____Phone#:_____

You **MAY / MAY NOT** (please circle one) leave information on my answering machine. Best number to reach you on:_____ or _____

You **MAY / MAY NOT** (please circle one) release my records by fax machine.
Fax number to send information:_____

You **MAY / MAY NOT** (please circle one) release my records by the US Postal Service.

You **MAY / MAY NOT** (please circle one) send information to me by email.

EMAIL ADDRESS:_____

SIGNATURE:_____ DATE:_____

PRINT NAME:_____RELATIONSHIP:_____

NAME OF PERSON IF PATIENT IS A MINOR:_____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have received, seen and/or read a copy of the Notice of Privacy Practices Form from Riverside Family Medicine.

Signature of Patient:_____ Date:_____

Relationship to patient :_____