865 SE Monterey Commons Blvd
Stuart, FL 34996
o 772-266-4713
f 772-888-9082

451 SW Bethany Drive, Suite 103
Port Saint Lucie, FL 34986
o 772-301-1354
f 772-281-2706

Authorization to Obtain and Release Information

Patient Name: ____ Date of Birth____

Phone Number: ____

This will authorize Riverview Community Mental Health Center to disclose to and/ or obtain from:
Name of Person or Organization: ____________________________________ Relationship: ____
Address: ____ Phone: _____________________ Fax: ________________________

Information to be released:

___ Psychiatric Evaluation
___ Laboratory Reports (HIV, Hepatitis, TB)
___Urine Analysis
___ Medical History
___Intake Evaluation
___ Discharge Summary
___ Medication Information
___Other information (specify): ____

___ Patient Letters (if applicable)
___ Presence in Treatment
___ Treatment Dates
___ Progress Notes
___ Return to Work
___ Scheduling Information/ Changes

The above-named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this practice. Your revocation will be honored except to the extent that is been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding handling of your health information are outlined in our Privacy Practices document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient, such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment expect to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility benefits.

I acknowledge, and consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.

I have read the above and authorize the disclosure of the protected health information as stated.

____ ______________________________
Patient/Legal Representative Signature Date

____
Printed Name