RIVERVIEW
Community Mental Health Center

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

584 NW University Blvd., Ste.300
Port Saint Lucie, FL 34986
o 772-301-1354
f 772-281-2706

Authorization to Obtain and/ or Release Information

This form allows us to obtain or release specific or all medical records of patient to a third party.

Patient Name: _____ **Date of Birth**_____

Phone Number: _____ **Expiration of Form:**_____

This will authorize Riverview Community Mental Health Center to disclose to and/ or obtain patient information from and/ or to:

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
___ Psychotherapy Notes

_____

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 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 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 protected health information as stated.

_____ _____

Patient/Legal Representative Signature **Printed Name**

_____

Date