Medical Records Release

Patient Name: _____ Date of Birth _____/_____/_____

Social Security # _____ Address:_____

City/State/Zip:_____ Telephone ( ) _____

I authorize the release of medical information as indicated below:

FROM:

Practice Name:_____

Address:_____

_____

Phone: ( )_____

Fax: ( )_____

TO:

Name: Riverview Family Medicine & Urgent Care

Address: 2450 India Hook Road, Suite B

Rock Hill, SC 29732

Phone: (803) 366-7443

Fax: (803) 620-9557

❒ I would like to pickup my records ❒ I would like my records faxed to the # above ❒ I would like my records mailed to address above

What to Release: The following records to cover the periods of : _____ *(please check the records you would like released:)*

❒ Office Visit notes ❒ Laboratory reports ❒ Pathology Report(s) ❒ Immunization record

❒ X-Ray report(s) ❒ X-ray Film(s) ❒ Other _____ ❒ All records

NOTE: The records listed below have special protection by laws. I authorize the release of information pertaining to: *(Please check)*

The diagnosis or treatment of AIDS, including results of HIV tests ❒ Yes ❒ No/NA

The diagnosis or treatment of drug and/or alcohol abuse ❒ Yes ❒ No/NA

The treatment and/or consultation for mental health or psychiatric disorders ❒ Yes ❒ No/NA

Purpose of the release: *Please indicate the reason for this release:*

❒ For another doctor, changing physician ❒ For another doctor, continuation of care ❒ Follow-up related to injury ❒ Worker's comp

❒ To obtain disability ❒ Use in a lawsuit ❒ Armed forces requirement ❒ Personal use ❒ Other _____

Expiration Date:

This authorization will expire in sixty days unless otherwise indicated here: Please change the expiration date to last for _____ days.

I understand this Authorization can be revoked at any time according Riverivew'sprivacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of this release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by Riverview Family Medicine, LLC and may potentially be re-disclosed by the party who received these records. Riverview Family Medicine, LLC, its employees and officers, and attending physicians are released for legal responsibility or liability for release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

_____ _____
Signature of the patient Date

_____ _____
Signature of legal representative and relationship to patient Date

_____ _____
Signature of witness Date

OFFICE USE ONLY
Records to patient

_____
Date

_____
Staff Initials

Riverview
FAMILY MEDICINE & URGENT CARE