Riverside Community Care

Leading the Way in Behavioral Healthcare & Human Services

RELEASE REQUEST FOR CONFIDENTIAL INFORMATION

Riverside Community Care is authorized to **Release to:** ☐ **And/ Or Request from**: ☐ **(Check one or both)**

Person/Organization: Telephone #: Fax **#:**

Address of Person/Organization:

Person/Program Requesting:

Person/Riverside Community Care Program Name: Telephone #: Fax **#:**

Riverside Community Care Program Address:

The following information and/or documents:

☐ Admission Summary

☐ Discharge Summary

☐ Physical Exam

☐ Psychiatric/Medication Evaluation

☐ Psychological Tests

☐ Treatment Planning Information

☐ Employment Related Information

☐ Clinical Treatment

☐ Substance Use/Treatment (I understand that all related information is protected under Federal and State law, 42CFR, Part 2, and I have the right to refuse release)

____

Person Served Signature

☐ HIV Related Information (I understand that all related information is protected under Federal Law and that I have the right to refuse release)______________________________________

Person Served/Parent/Guardian's Signature

☐ Consults

☐ Other

☐ **Verbal/Telephone Communication**

☐ **Direct Transmission from Riverside's EHR to receiving organization's EHR**

RE:

Note*: There is the potential for information released based on this document to be re-disclosed by the recipient.*

For the PURPOSE of: ☐ Evaluation/Intake ☐ Discharge/Aftercare Planning ☐ Treatment Planning ☐ Other

Legal Matter (specify):

This Authorization Expires on: **OR** (1 Year from Consent)

It is my understanding that this information will be used solely for the purpose described above. I understand that I may revoke my permission at any time except after the information has already been released, and to the extent that action has been taken in reliance on it. I understand that I have the right to revoke this authorization, in writing, at any time, except where use or disclosure may have been already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance.

NOTICE TO RECIPIENT OF THESE RECORDS: If this information contains information identifying the patient as having or having had a substance use disorder either directly, or indirectly, the federal rules prohibit you from making any further disclosure of information in this record without the patient's permission. (42 CFR s.2.31)

For Records Requests FAX TO: 781-320-9136 c/o Riverside Community Care's Records Manager (Quality Management Dept.)
OR submit this form to the Program Manager where person served receives services at Riverside

Person Served: Date:

Parent/Legal Guardian: Date:

REFUSAL:
I do **not** authorize Riverside Community Care to release or request information at this time.
Person Served/Parent/Guardian Signature: Date: