CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ____

Maiden or Other Name(s): ____________________ **Date of Birth:** ______________

Mailing Address: ____
(Street) (City) (State) (ZIP)

Physical Address: ____
(Street) (City) (State) (ZIP)

I hereby authorize information **FROM:**

Name: ______________________

Address: ______________________

City/State/Zip: ______________________

Phone: ____________ Fax: ________

☐ River Health & Wellness, LLC

To be released **TO:**

Name: ______________________

Address: ______________________

City/State/Zip: ______________________

Phone: ____________ Fax: ________

☐ River Health & Wellness, LLC

I am requesting the following information to be released:

☐ Abstract of record (includes: history and physical, operative reports, consultations, discharge summaries, laboratory findings, radiology reports, and other significant findings.)

☐ Entire medical record ☐ Other: ______________________________

Date(s) of service: ______________________ Send via ☐ Mail ☐ Fax ☐ Other:

I permit this confidential information to be released for the following purpose:

☐ Continuing medical treatment. ☐ Self/Personal Copy. ☐ Litigation ☐ Other (specify reason):

☐ Insurance Claims (company name): ______________________________

☐ Workman's Comp (company name): ______________________________

I understand that this consent permits River Health & Wellness, LLC (RHW) to use and disclose my protected health information to carry out treatment, payment, or healthcare operations. I understand I have the right to request restrictions or revoke this authorization in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. I understand the information in my medical record may include information relating to sexually transmitted infections, HIV/AIDS, behavioral or mental health services, and/or treatment for alcohol and drug abuse. Having read the above information, I hereby release, hold harmless and agree not to sue RHW, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

______________________________ **(Print patient's name)**

______________________________ **(Signature of patient) Date:** ____________

______________________________ **(Signature of legally authorized person)**