Riverside Community Care

Leading the Way in Behavioral Healthcare & Human Services

RELEASE REQUEST FOR CONFIDENTIAL INFORMATION

PERSON SERVED: _____**DOB**: _____**RECORD #**: _____

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:

❑ Release Riverside records for the following date range: _____to_____

❑ Admission Summary
❑ Clinical Treatment
❑ Consults

❑ 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) **To release, check box and sign**

_____

Person Served

❑ Discharge Summary
❑ Employment Related Information
❑ Physical Exam

❑ HIV / Sexually Transmitted Disease Related Information (I understand that all related information is protected under Federal Law and that I have the right to refuse release) **To release, check box and sign**

_____

Person Served/Parent/Guardian's Signature

❑ Psychiatric/Medication Evaluation
❑ Psychological Tests
❑ Treatment Planning Information

❑ Genetic Information (I understand that all related information is protected under Federal Law and that I have the right to refuse release) **To release, check box and sign**

_____

Person Served/Parent/Guardian's Signature

❑ Other_____

Mode of Communication:

❑ Verbal/Telephone Communication
❑ Written Communication
❑ Direct Transmission from Riverside's EHR to receiving organization's EHR

Communication regarding: _____

For the PURPOSE of: ❑ Evaluation/Intake ❑ Discharge/Aftercare Planning

❑ Treatment Planning ❑ Other _____

Legal Matter (specify): _____

This Authorization Expires on: _____ (1 Year From Consent Date)

It is my understanding that this information will be used solely for the purpose(s) 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. There is the potential for information released based on this document to be re-disclosed by the recipient.

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 rule prohibits you from making any further disclosure of information in this record without the patient's permission. (42 CFR s.2.31)

Please note that enrollment in Riverside service(s) are not conditional on completing this release but the effectiveness of those supports may be limited by what data the enrolled individual allows to be shared.

AUTHORIZATION:

Person Served:_____Date:_____
Please print and sign name

Parent/Legal Guardian:_____Date:_____
Please print and sign name

REFUSAL:

I do **not** authorize Riverside Community Care to release or request information at this time.

Person Served/Parent/Guardian:_____ Date:_____
Please print and sign name

FAX PAGES 1 AND 2 OF COMPLETED FORM TO: 781-320-9136 c/o Riverside Community Care's Records Manager (Quality Management Dept.)