PATIENT AUTHORIZATION FOR DISCLOSURE OF PHI
(PERSONAL HEALTH INFORMATION)

RELEASE OF MEDICAL RECORDS

I, _____, wish to obtain a copy of my medical records. The reason I am requesting my records is: _____

_____

_____

I would like my records sent to: _____

_____

I would like the following released:

Dates and charges of service: _____

A summary of my sessions and treatment: _____

My entire record: _____

Other (explain): _____

Social Security Number: _____

Date of Birth: _____

Phone Number: _____

I understand that if I have any questions about my clinical records or the content within, I can contact The River Wellness Group and someone will meet with me to discuss my records.

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 ('HIPAA'), 45 CFR, Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time and that that any notice to revoke consent must be in writing.

Name of Client/Parent (print) _____

Signature _____ Date _____