

RIVERSIDE RECOVERY



Patient Name: _____

Address: _____

City, State, ZIP Code: _____

Date: _____

Riverside Recovery of Tampa, LLC
4004 N RIVERSIDE DRIVE
TAMPA, Florida 33603

Dear Riverside Recovery of Tampa, LLC:

I am writing to request a copy of my medical records.

I am currently a patient or was a patient of Riverside Recovery of Tampa, LLC. Enclosed is a signed Authorization to Release Medical Records. I am requesting the records for this reason:

If there is a charge for copying the records, please submit a statement with the records and I will remit payment upon receipt of the records.

Please contact me at the above address if you have any questions or need additional information. I can be reached by phone at _____ or

Alternate Number: _____.

Thank you for your attention to this matter.

Sincerely,

Patient Signature

Enclosure

RIVERSIDE RECOVERY



AUTHORIZATION TO RELEASE MEDICAL RECORDS

1. PATIENT INFORMATION.

Name: _____

Address: _____

City, State, ZIP Code: _____

Date of Birth: _____

2. AUTHORIZATION FOR RELEASE. I hereby authorize Riverside Recovery of Tampa, LLC of 4004 N RIVERSIDE DRIVE, TAMPA, Florida 33603, to release, disclose, and deliver the medical information described below to:

Authorized Recipient: _____

Name of Recipient: _____

Company or Business Name: _____

Address: _____

City, State, ZIP Code: _____

Fax Number: _____

3. SPECIFIC AUTHORIZATION. I specifically authorize the release of all medical information relating to the above-named patient including but not limited to the following categories protected by state or federal law: (1) Substance abuse (drug or alcohol) treatment (2) Mental health treatment and (3) HIV-AIDS-related information, and private session therapy progress notes if such information is contained in the records. This request includes any reports, correspondence, test results, and any other information contained in the records, whether generated by the authorized provider or another entity.

I do not give permission for any other use or redisclosure of this information.

Dated: _____

Patient Signature

RIVERSIDE RECOVERY



4. **REDISCLASURE.** This release does not authorize redisclosure of medical information beyond the limits of this consent. The Recipient of this information is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization. The following written statement should accompany certain disclosures:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and 45 CFR Parts 160 and 164). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and 45 CFR Parts 160 and 164. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I specifically understand and agree that the REDISCLASURE requirements set out above will apply to these records.

5. **VALIDITY.** I understand that this authorization will automatically expire one year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I authorize the release of information as indicated above.

Dated: _____

Patient Signature