RIVERSIDE
MEDICAL GROUP

CONSENT TO RELEASE MEDICAL RECORDS TO RIVERSIDE MEDICAL GROUP

This consent is valid for three (3) months after the date of patient's/representative's signature

Patient Name:_____ Birthdate:_____

To _____

Full Street Address _____ Phone:_____

City, State, Zip Code _____ Fax_____

I, _____, for the purpose of patient treatment, authorize you to release to

(Name of patient or representative -- please print)

Riverside Medical Group - Provider Name: Riverside Cancer Institute

Full Street Address 200 Riverside Drive Phone: (815) 933-9660

City, State, Zip Code Bourbonnais, Illinois 60914 Fax (815) 929-0014

copies of this patient's medical record regarding care given from _____ to _____, specifically (check):

- ☐ Discharge Summary
- ☐ History & Physical Examination
- ☐ Consultation Reports
- ☐ Operative Reports
- ☐ Cardiac Catheterization Reports
- ☐ Pathology Reports
- ☐ Emergency Dept. Records
- ☐ Physician Progress Notes
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Neurology Reports (e.g., EEG, EMG)
- ☐ Cardiology Reports (e.g. EKG, echo, stress test, holter, event monitor)
- ☐ Rehab Notes (e.g., PT, OT, Speech)

☐ Preventative services/wellness care (mammography, colon cancer screening, colonoscopy, Pap smear, A1C results, immunizations & vaccinations, including influenza & pneumonia vaccines)

☐ Other:_____

I fully understand that this release will include information relating to the testing, examination, diagnosis, treatment and/or referral regarding the conditions listed below unless initialed by the signing party(ies):

_____AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
_____Alcohol and/or drug use or dependence
_____Mental health condition or developmental disability
_____Sexually-transmitted disease
_____Genetic Disorders

I understand that I may inspect and have copies of the information I am releasing and that I may revoke this consent at any time (except to the extent that the disclosing facility already acted on this consent to release medical records) by notifying the facility in writing that I am revoking this consent.
I understand that the information identified above cannot be released unless I sign and date this consent form and that continuity of care may be impaired if I do not allow the information to be released. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on signing this consent.
I release the receiving facility from all legal responsibility and liability for the information released according to the terms of this written consent. I understand that there is the potential for this protected health information to be re-disclosed by Riverside Medical Center and thus no longer protected under the HIPAA privacy rule.

SIGNED:_____ DATE:_____

If you are not the patient, specify your relationship to the patient and the reason you are signing this consent for him:

RELATIONSHIP & REASON:_____

Second signature (if required):

SIGNED:_____ DATE:_____

WITNESS:_____ DATE:_____

751136 11/18