RIVERSIDE SURGICAL ASSOCIATES, INC.
Consent/Authorization Form for Use and Disclosure of Patient Information

I, _____ _____, hereby ☐ **authorize** (or**)** ☐ **do not authorize**
Patient Name ***Date of Birth***

Riverside Surgical Associates, Inc. to use and/or disclose the following **protected health information (PHI):**

Information to be disclosed may include, but is not limited to, medical history, chart notes, diagnostic test results, x-ray reports, prescriptions, operative & pathology reports, hospital records and records received from other healthcare providers.

Disclosures that Require Special Authorization: By marking any of the boxes below, I specifically authorize the use or disclosure of information containing these categories of highly confidential information:

☐ HIV or AIDS Test Results or Information
☐ Sexually Transmitted Diseases
☐ Mental Health or Developmental Disabilities
☐ Information on Drug or Alcohol Abuse

Authorization is limited to the following condition(s) or date(s) _____
(Complete if you wish to limit your authorization to a specific condition or date)

Check all of the boxes below to whom we may disclose your information to:

☐ Short-Term/Long-Term Disability Paperwork
☐ Information Release to Employer
☐ Information Release to School
☐ FMLA Paperwork for Self, Spouse, Parent or Child
☐ Life or Health Insurance Applications
☐ Other Healthcare Providers or Facilities
☐ Airlines or Travel Facilities
☐ Fitness Center or Rehabilitation Center
☐ Other ***(Provide description below)***
_____

Please mail or fax records to: _____

_____

This authorization will expire one year from the date of signature, unless you specify differently below:

_____

Riverside Surgical Associates, Inc. ***Notice of Privacy Practices*** **has been provided to me.** I have the right to review this notice prior to signing this acknowledgement/authorization. Riverside Surgical Associates, Inc. may call my home or other designated location, leave a message on voice mail or in person, fax or e-mail to a designated location, in reference to any items that assist the practice in carrying out ***treatment, payment*** and health care ***operations***; such as appointment reminders, insurance items, patient statements and any calls pertaining to my clinical care. Please refer to our *Notice of Privacy Practices* for a more complete description of such uses and disclosures.

I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to Riverside Surgical Associates, Inc. at 3545 Olentangy River Road-Suite 525-Columbus, Ohio 43214. I understand that a revocation is not effective to the extent that Riverside Surgical Associates, Inc. has relied on the use or disclosure of the PHI. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Riverside Surgical Associates, Inc. will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure. I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)

_____ _____
Signature of Patient or Patient's Representative Date