

**RIVERSIDE COUNTY REGIONAL MEDICAL CENTER  
AUTHORIZATION FOR USE OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

Name of Patient: \_\_\_\_\_

Date: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I hereby authorize the use and disclosure of protected health information about the above patient as follows:

- A. This is to request and authorize Riverside County Regional Medical Center to release my medical, psychiatric, alcohol, and/or drug abuse records for the following purpose:

\_\_\_\_\_  
(for what purpose is the protected health information to be used)

- B. Description of patient's protected health information to be released:

\_\_\_\_\_  
(what protected health information are you allowing to be released)

- C. The records are to be released to: (give name and address of where records are to be sent)

\_\_\_\_\_  
\_\_\_\_\_

This authorization will expire on: \_\_\_\_\_

(If no date listed then authorization will remain in effect until six months from the date signed)

\_\_\_\_\_  
Signature of Patient/Personal Representative

\_\_\_\_\_  
Personal Representative's Authority to Act on  
the Patient's Behalf

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Address and Telephone Number of Patient/Personal Representative

I understand that I have the following rights with respect to this Authorization:

1. Riverside County Regional Medical Center will provide me with a copy of this Authorization.
2. Riverside County Regional Medical Center may not further disclose the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.
3. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits.
4. I may revoke this Authorization at any time by mailing or personally delivering a signed, written revocation to Riverside County Regional Medical Center at 26520 Cactus Ave., Moreno Valley, California 92555. Such revocation will be effective upon receipt, except to the extent that the recipient has taken action on this Authorization.

The “Personal Representative” is any of the following:

- For an incompetent adult:
  - A conservator of the patient’s person
  - An agent appointed by the patient under a power of attorney for health care
- For a minor who does not have special legal authority to sign an authorization:
  - Parent
  - Guardian
  - Any other person *in loco parentis*
- Any other individual who has the legal authority to make health care decisions on the patient’s behalf or
- An executor or administrator of the patient’s estate