Riverside Radiology and Interventional Associates, Inc.

PATIENT'S REQUEST FOR RELEASE OF INFORMATION

PATIENT (OR LEGAL REPRESENTATIVE): Please complete, date and sign where indicated.

I hereby authorize Riverside Radiology and Interventional Associates, Inc. to release all appropriate health information on the below patient.

Patient Name: _____ **Date of Birth:** _____
(please print)

Patient Address: _____
(address, city, state, zip code)

Information to be released 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 are listed below.

By checking the box (s) below I specifically authorize the 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 and/or date)

Name and address to send requested health information (if different than above):

Doctor/Hospital/Other: _____
(please print)

Mailing Address: _____
(please print)

_____ I would like a copy of my health information.

_____ _____
Signature of Patient or Legal Representative **Date**

Riverside Office
3525 Olentangy River Road
Suite 5360
Columbus, Ohio 43214

Lewis Center Office
7651 Stagers Loop
Delaware, Ohio 43015