"Connecting Communities – Committed to Caring"

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION FORM

I, _____ hereby authorize Riverside Health Care Facilities Inc. to disclose the following personal information.

_____
_____
_____
(Description of personal health information to be disclosed and dates of contact/hospitalization)

to _____
_____
(Name and Address of person/agency requesting information)

from the records of _____
(Name of Patient) (Birth date)

Mailing Address of Patient: _____
_____
_____

I understand that this personal health information is to be used **only** by the recipient for the purposes of:

- □ Delivery of direct patient care
- □ Research – Please specify type _____
- □ Fundraising – Name of Organization _____
- □ Administration of Health Care System
- □ Other: _____

I hereby waive any and all claims against Riverside Health Care Facilities Inc. in connection with the disclosure of this personal health information.

Signed by: _____
(Patient or Substitute Decision-Maker)

Date: _____ _____
(Relationship to Patient)