RIA
Behavioral Health Ltd.
Tel: 920.843.9162
Fax: 920.610.7190

Authorization to Release Protected Health Information

Patient Name: _____
Date of Birth: _____ / __ / _____
I hereby authorize **RIA Behavioral Health Ltd.** to:
☐ Request from ☐ Send to ☐ Exchange with
Provider / Person / Organization:
Name: _____
Office / Relationship to Patient: _____
Phone Number: _____
Date(s) of Service Covered:
☐ All dates of service ☐ Specific dates: From _____ To _____

Information to Be Released
(Please check all that apply)
☐ Patient Care Status
☐ Diagnosis
☐ Treatment Plans
☐ Medications
☐ Psychological Testing Results
☐ Progress Notes
☐ Alcohol/Drug Treatment or Evaluation
☐ Payments / Billing
☐ Scheduling
Other Information (please specify):

Any information to be excluded:

Purpose for Requesting Information
(Please check all that apply)
☐ Coordination of Care
☐ Legal
☐ Insurance / Worker's Compensation
☐ Personal / Self
☐ Emergency Contact / Support
☐ Other: _____

Important Information About Your Rights

- **Right to Inspect or Copy** – You may inspect or request copies of the health information authorized for disclosure by contacting our office.
- **Right to Receive a Copy** – If you sign this authorization, you are entitled to request and receive a signed copy.

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- **Right to Refuse** – You are not required to sign this authorization. Your care, benefits, or treatment will not be affected if you choose not to sign.
- **Right to Withdraw** – You may revoke this authorization in writing at any time. Contact our office to obtain a revocation form. Any disclosures made before we receive your written revocation will remain valid.

Note: If the recipient of this information is not a health care provider or other entity covered by federal privacy laws, the disclosed information may no longer be protected and could be redisclosed.

Expiration of Authorization

This authorization shall remain in effect:

☐ Until this date: ____ / ____ / _____

☐ For one year from the date of signature

☐ It does not expire

A photocopy or facsimile of this authorization will be considered as valid as the original

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Signatures:

Patient Name:

Guardian Name (if patient is 13 and younger):

Signature (Required if Patient is age 14 or older):

Date: _____ / _____ / _____