River City
Psychiatric Services, LLC
Phone: (507)208-7629
Fax: (507) 607-8671

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name: _____ DOB: _____

Authorization for Use/Disclosure of Information:

I, _____ authorize the following (clinic/organization/ provider)
_____ to disclose the following information:

_____ Intake and Clinical Notes, including amendments
_____ Current Medication Record
_____ Psychiatric Diagnostic Evaluation Results
_____ Treatment Plan & Treatment Summary
_____ All Test & neuropsychological evaluations, including but not limited to labs, Genesight, Genomind, and CEFI Educational Records.
_____ Inpatient Discharge Reports
_____ Any and All Records
_____ Other _____

TO:
River City Psychiatric Services, LLC
902 E 2nd St. Ste 109
Winona, MN 55987

The purpose of this authorization is: (check all that apply)

☐ Continuation of care
☐ Treatment Planning/Collaboration of Care
☐ Other: _____

I authorize River City Psychiatric Services, LLC to receive the documents by fax at (507)607-8671 or email at fd@rivercitypsychservices.com

This authorization ends: (check one)

☐ On (date)_____
☐ When care is terminated by either the patient or provider
☐ When the following event occurs: _____

Signature _____ Date: _____
Patient/parent/guardian

Relationship to patient: _____