RIGGS COMMUNITY HEALTH CENTER
AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

Patient Name _____ DOB _____
Address _____
City _____ State _____ ZIP _____
Social Security # _____-_____-_____ Phone # _____

I hereby request RIGGS to allow:
Name of individual _____ Relationship _____
Address _____ City, State, ZIP _____
Phone # _____

☐ To bring my child to appointments
☐ To make appointments for me
☐ To receive PHI/medical records
☐ To take messages containing protected health information (PHI)
☐ To pick up my prescriptions (excludes controlled substances)
☐ To do all of the above
☐ Other (specify) _____

Please select a PASSWORD that you and the recipient can use for identification purposes:
_____

Unless I mark the following box, I authorize the above selected types of information to include mental health, drug/alcohol abuse, and communicable disease (HIV/AIDS, STD) information.

☐ **DO NOT** disclose any information regarding mental health, drug/alcohol abuse, or communicable disease information.

This authorization will remain valid until it is revoked or it expires. This authorization will expire: _____ (Expiration Date or Defined Event. For example: 1/1/2030, when child reaches 18). If I fail to specify an expiration date, event, or condition, this authorization will continue until I cease to be a patient of Riggs, or until I revoke it in writing.

I understand that I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to: Riggs Community Health Center Health Information Services 1716 Hartford St. Lafayette, IN 47904. The revocation will be effective 2 business days after receipt by the HIPAA Privacy Compliance Officer or Health Information Services Staff Member.

I understand that I am under no obligation to sign this authorization as a condition to providing health care treatment to me. I understand that upon release and disclosure of the protected medical records and in formation, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Signature of patient/parent/guardian _____ Relationship to patient _____

Patient Name Printed _____ Date _____

Printed Name if not Patient _____

☐ Authorization Accepted: _____ Date _____
HIPAA Privacy Officer or Health
Information Services Staff Member

☐ Authorization NOT Accepted: _____ Date _____
HIPAA Privacy Officer or Health
Information Services Staff Member

Printed Name _____

Reason NOT Accepted _____
_____