RIVERSIDE PHYSICIAN NETWORK
COMMUNICATION CONSENT AGREEMENT
1650 Iowa Ave, Ste 220
Riverside, CA 92507
(951) 788-9800
(951) 788-0098-Fax

I UNDERSTAND THAT UNDER FEDERAL LAW (HIPAA), RIVERSIDE PHYSICIAN NETWORK MAY **NOT** RELEASE ANY MEDICAL INFORMATION TO ANY INDIVIDUAL WITHOUT MY EXPRESS WRITTEN PERMISSION. LAW ENFORCEMENT AND COURT ORDER ARE TWO EXCEPTIONS TO THIS REQUIREMENT. I, THEREFORE, **GIVE** THEM PERMISSION TO RELEASE MEDICAL INFROMATION ON MY BEHALF, TO THE FOLLOWING PERSON(S):

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE #: _____ AGE: _____ BIRTHDATE: _____

DRIVERS LICENSE #: _____ SOCIAL SECURITY #: _____

OTHER FORMS OF IDENTIFICATION: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE #: _____ AGE: _____ BIRTHDATE: _____

DRIVERS LICENSE #: _____ SOCIAL SECURITY #: _____

OTHER FORMS OF IDENTIFICATION: _____

Authorized Methods of Communication (✓ Check all that apply)			
☐ Residence Telephone	☐ Work Telephone	☐ Written Correspondence	☐ Other (Specify)
Number: ( )	Number: ( )	☐ Mail/Delivery Service	
☐ Leave call back number only; do not leave message	☐ Leave call back number only; do not leave message	☐ Fax: ( )	
☐ Okay to leave detailed message with person	☐ Okay to leave detailed message with operator	☐ E-Mail @ Residence:	
☐ Okay to leave detailed message on answering machine	☐ Okay to leave detailed message on personal voice mail	☐ E-Mail @ Work:	

MEMBER SIGNATURE: _____ DATE: _____