Hill Physicians

Authorization for Release of Medical Information

Please fill in

Individual's First and Last Name _____

Date of Birth: _____ Health Plan Member No.: _____

I hereby authorize Hill Physicians Medical Group, Inc., to use and disclose my protected health information ("Health Information") as defined by Federal and state law, in the manner described below. I understand that this authorization is voluntary. I also understand that if the person or entity authorized by this document to receive my Health Information is not a health plan or health-care provider, then the disclosed Health Information may no longer be protected from further disclosure by state or federal law.

Any and all of the following Health Information may be disclosed by Hill Physicians:

☐ Medical Records ☐ Claims/Billing Information ☐ Drug/Alcohol Abuse Records
☐ Mental Health Records (which may be retrieved from your provider) ☐ HIV Test Results

This Health Information may be disclosed to: _____

Mailing Address: _____

_____

Phone number: _____

Relationship to Individual: ☐ Personal Representative ☐ Attorney ☐ Spouse/Relative

☐ Other _____

This Health Information will be used only for the purpose of allowing:

_____

_____

_____

—Form continued on back

Please fill in

I understand that my health care will not be affected if I do not sign this form.

I understand that this authorization will expire on: _____ or one year from the date of my signature below, whichever is earlier.

I also understand that I may revoke this authorization at any time by notifying Hill Physicians in writing. I understand that my revocation of this authorization will not affect any actions taken by Hill Physicians in reliance on this authorization prior to the time it received my revocation.

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient (to the extent minor could not have consented to the care).
- ☐ Guardian or conservator of an incompetent patient.
- ☐ Beneficiary or personal representative of deceased patient.

Please return this form to Hill Physicians by mail or fax:

Mail

Hill Physicians Medical Group
Attn: Director, Customer Service
P.O. Box 5080
San Ramon, CA 94583

Fax

(925) 327-6626
Attn: Director, Customer Service