Hill Physicians
Your health. It's our mission.

# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Hill Physicians Member Name: ___________________________________________**

**Hill Physicians ID Number: _____________________________________________**

I hereby authorize Hill Physicians Medical Group, Inc. ("Hill Physicians") to use and disclose my individually identifiable health information ("PHI") in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI from Hill Physicians, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from Hill Physicians. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

This authorization covers the following PHI:

***Category of PHI***

| | | |
|---|---|---|
| ☐ Medical Records | ☐ Claims/Billing Information | ☐ Mental Health Records |
| ☐ Drug/Alcohol Abuse | ☐ HIV Test Results | ☐ Genetic Test Results |

***Amount of PHI***

☐ Entire PHI in the chosen category [*Example* – All "HIV Test Results"]

☐ Please limit use and disclosure of my PHI to: ____________________________________

_____________________________________________________________________________

[*Example* – "Laboratory results from July 1998"; "Mental health records from January 2001 to present"]

The recipient(s) of my PHI is (are): ____________________________________________

_____________________________________________________________________________

This authorization will expire ___________________________ but no later than one (1) year from the date of my signature below.



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Hill Physicians Member Name:

_______________________________________________

I authorize my PHI to be used and disclosed:

☐ At my request

☐ For ____________________________________________________________

[SPECIFY PURPOSE]

☐ For CLINICAL TRIAL: I understand that Hill Physicians may refuse provision of research-related treatment unless I sign an authorization for use and disclosure of my PHI for the research. I understand that I will not have access to my PHI while the clinical study is open, but will be provided access when the study is closed.

☐ For MARKETING: I understand that Hill Physicians may receive monetary compensation from the party receiving my PHI or that party's affiliates.

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying Hill Physicians in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by Hill Physicians in reliance on this authorization before Hill Physicians receives my request for revocation or modification. I must sign my written request and send it to:

Hill Physicians Medical Group
Attn: Medical Records Department
2401 Crow Canyon Road
San Ramon, CA 94583

Signed: ______________________________ Dated: __________________

If not signed by the patient, please indicate relationship:

☐ Parent, guardian or caregiver of a minor patient.
☐ Guardian or conservator of an incompetent patient.
☐ Beneficiary or personal representative of a deceased patient.
☐ Other ___________________________________________________________

[SPECIFY RELATIONSHIP]



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