Hill Physicians

Authorization for Release of Medical Information

To request that Hill Physicians Medical Group releases your Claims/Billing Information, please complete and mail the request form. For release of medical information pertaining to any and all of the following Health Information, please contact your provider's office directly:

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

Is this request for yourself? (Required)

☐ **Yes,** This Request is for Myself ☐ **No,** This request is on behalf of someone

Individual's first and last name (Required)

Prefix _____ First _____ Last _____

Individual's Date of Birth (Required) _____/_____/_____

Individual's Phone (Required) (_____) _____

Individual's Health Plan Member Number (Required) _____

Consent (Required)

☐ 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.

☐ Claims/Billing information

This health information may be disclosed to: (Required)

First _____ Last _____

Mailing Address _____

Phone Number (_____) _____

Relationship to Individual: (Required) ☐ Personal Representative ☐ Attorney ☐ Spouse/Relative

☐ Other (Describe) _____

—Form continued on back

Describe Relationship to Individual: (Required) _____

_____

This health Information will be used only for the purpose of allowing: (Required)_____

_____

_____

Consent (Required)

☐ I understand the following:

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

I understand that this authorization will expire 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: (Required)_____ Dated: (Required) ____/____/____

Print your full name here:_____

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: Customer Service
P.O. Box 5080, San Ramon, CA 94583

Fax

(925) 327-6626
Attn: Customer Service

