**SPRINGHILL MEDICAL GROUP - 2220 Gladstone Drive, Ste 3, Pittsburg, Ca 94565**
**Phone: (925) 432-3318 Fax : (925) 432-0886**

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**Authorization to disclose/release patient Health Information/Medical Records**

**I hereby authorize:** **Springhill Medical Group**

**To disclose to:** ______________________________________________
**Name of receiving party**

______________________________________________
**Address** **City** **State** **Zip**

**Records and information pertaining to:**

**Name of Patient** ______________________________ **Date of Birth:**____________
**Address:**____________________________________ **Telephone:**_______________

**Duration: This authorization shall become effective immediately and shall remain in effect until _________________ or for one year from the date of signature.**
**Reason for release of information:** ______________________________________________
**Revocation: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this authorization.**
**Note: I understand that should chose to release my medical information to an entity or individual that is not legally required to keep said information confidential that it may no longer be protected by state or federal laws.**
**Redisclosure: I understand that the requestor may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.**
**Refusal and limitations: I understand that should I refuse to sign or limit this authorization my ability to obtain treatment will not be curtailed in any way.**
**Copy of form: The patient has the right to receive a copy of this form.**
**Fees: II agree to pay reasonable clerical and copying costs for these records.**

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******* This section MUST be completed – or records will not be sent: ******

**Records to release : _________All records, Type:______________, Date range: _____________**
**Check above if all records are requested**
**Exclude records:**
_________ **Exclude HIV test results** _______ **Exclude Psychiatric information**
_________ **Exclude substance use information** _______ **Exclude other health info:**

**Date:** __________________________________ **Signature:** _______________________________

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**Medical Records requested will be fulfilled within 7 business days whenever possible. This form must be received by our business office at fax 925 432-0886 or delivered to 2220 Gladstone Drive, St 3 Pittsburg, Ca to ensure fulfillment at the time frames above. (9/2016)**