SPRINGHILL MEDICAL GROUP

Authorization to disclose/release patient Health Information/Medical Records

I hereby authorize: _____

_____

Address City State Zip

To disclose to : Springhill Medical Group – 2220 Gladstone Dr # 3, Pittsburg, Ca 94565
Email to: medicalrecords@springhillmed.com
Requesting provider ; _____

Records and information pertaining to:

Patient Name : Dob :
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: Il agree to pay reasonable clerical and copying costs for these records.

***** 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: _____

Mailing Address: 2220 Gladstone Drive, Suite 3 Pittsburg CA 94565-5123

Medical Records phone (925) 432-3318 option 6 FAX (925) 432-0886

Medical Records requested will be fulfilled within 7 business days whenever possible. This form must be received by our business office by email at medicalrecords@springhillmed.com, by fax 925 432-0886, or delivered to 2220 Gladstone Drive, St 3 Pittsburg, Ca to ensure fulfillment at the time frames above.