HILLCREST INTERNAL Medicine

Date of request: _____

HILLCREST INTERNAL MEDICINE
Fourth Ave, Suite 505
San Diego, CA 92103
Phone (619) 298-1318 Fax (619) 298-0843

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:	
DOB:	SSN:

☐ I authorize Hillcrest Internal Medicine to obtain information from: (PLEASE FAX TO 619-298-0843)	☐ I authorize Hillcrest Internal Medicine to release information to:
Name of Provider or Facility:	
Address:	
Phone:	Fax:

PURPOSE FOR THIS REQUEST: (Check one) ○ Continuing Care ○ Insurance ○ Personal ◉ Other

TYPE OF RECORDS REQUESTED: (Check all that apply)

- ☐ Pertinent information: most recent progress notes, labs, radiology
- ☐ Specific information
  - ☐ Progress notes ☐ Radiology ☐ Lab Results ☐ Billing
  - ☐ Treatment summary (includes H&P, labs, radiology, op reports, pathology, etc.)
  - ☐ Other: (please be specific)
- ☐ Entire record (for transferring care)

Date(s) of Service:

AUTHORIZATION TO RELEASE STATUTORILY PROTECTED INFORMATION

- ☐ Mental Health treatment information Initials:
- ☐ HIV test results/related information Initials:
- ☐ Substance abuse diagnosis/treatment information Initials:

AUTHORIZATION VALID FOR: (Check one)

- ☐ This request only.
- ☐ One Year from the date of this authorization **OR** (insert date) This authorization applies to the records of the treatment received on or prior to the date of this authorization.
- ☐ This request and for medical records of any **future** treatment of the type described above until:

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by the privacy regulations, the information stated above could be disclosed.
- There may be a charge for the requested records.
- I have a right to receive a copy of this authorization.

Signature of Patient or Legal Representative: Date:

Relationship to Patient (if requestor is not patient):