Incoming Record Release Authorization

To:

Address:

City: State: ZIP:

Phone: Fax:

I authorize and request you send a complete copy of my medical records to:

Hill Park Medical Center

435 Petaluma Ave. #150

Sebastopol, CA 95472

Phone: 707-861-7300 Fax: 707-823-8568

To include information regarding my diagnosis and treatment with you from

_____/_____/_____ to _____/_____/_____.

- ▢ All Records
- ▢ Labs
- ▢ Imaging (CAT Scan, Ultrasound, X-Ray)
- ▢ Doctor's Notes
- ▢ Other

If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if **I place my initials** in the applicable space next to the type of information:

_____ Drug/Alcohol diagnosis, treatment or referral information

_____ Mental Health Information – including provider notes

_____ HIV/AIDS Information

_____ Genetic Testing Information

Patient's Name: _____

Date of Birth: _____/_____/_____

Authorized Signature: _____

Date Signed: _____/_____/_____