HILL PARK
INTEGRATIVE
MEDICAL CENTER

Incoming Record Release Authorization

From: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

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

Hill Park Integrative Medical Center
435 Petaluma Ave. #150
Sebastopol, CA 95472
Tel: 707-861-7300 Fax: 707-823-8568

To include information regarding my diagnosis and treatment with you from the following dates:

_____/_____/_____ to _____/_____/_____

□ All Records
□ Labs
□ Imaging (CT Scan, Ultrasound, X-ray)
□ Doctor's Notes
□ Other _____

If the information to be 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 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 Name **Date of Birth**

_____ _____
Signature **Date Signed**