SAN BERNARDINO MEDICAL GROUP, INC

AUTHORIZATION FOR RELEASE and/or
DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize the person/entity below to release and /or disclose of my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that the recipient of my PHI may not further disclose the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. I further understand that the health care provider will not condition the provision of care or the receipt of benefits on the signing of this authorization. **** RECORDS OVER 10 PAGES ARE SUBJECT TO A PROCESSING FEE ****

REQUEST RECORDS FROM:

San Bernardino Medical Group
1700 N Waterman Ave
San Bernardino, CA 92404
Phone: (909) 883-8611
Fax: (909) 881-5707

SEND RECORDS TO:

____
Name of Person / Facility Receiving Records

____
Street Address

____
City, State, and Zip Code

____
Area Code and Phone Number

____
Name of Patient (Please Print)

____
Date of Birth

____
Address

____
City, State, and Zip Code

____
Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect until ___________ (Enter Date) or for six months from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information form the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

SPECIFY RECORDS TO BE RELEASED AND / OR DISCLOSED

General medical records may include references or referrals to mental health, alcohol and drug treatment, if noted by my provider, but not the actual medical records themselves, unless specifically requested below.

- All General Medical Information, or
- General Medical Information: From __________ to __________
- Laboratory Results: From ________ to ________
- X-ray Results: From _________ to ________ • Report and or • Films (Check One)
- Mental Health Records: From _________to ________ Initial ______
- Alcohol / Drug: From __________ to _________ Initial ______
- HIV Test Results: From __________ to ________ Initial ______
- Claims / Billing: From ___________ to __________
- Outside Records: From ____ From:___________ to ____________
  Name of Person or Facility

____
Signature of Patient, Parent or Guardian

____
Indicate Relationship

____
Date