VonStieff MEDICAL GROUP

# Authorization for Use or Disclosure of Health Information

Name: _____
Last First Middle Initial

SSN: _____ Birth Date: _____

Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize my health information to be sent **FROM**:

Clinic or Doctor: VonStieff Medical Group

Phone: (925) 680-8933 Fax: (925) 680-7635

Street Address: 2481 Pacheco Street

City: Concord State: CA Zip: 94520

I hereby authorize my health information to be sent **TO**:

Clinic or Doctor: _____

Phone: _____ Fax: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Send information via: ☐ Mail ☐ Fax

Send the following:
☐ All of my medical records
☐ All medical records from: _____ to _____
☐ The following records or type(s) of information:

_____

_____

_____

**I acknowledge that by signing this form I am authorizing VonStieff Medical Group to send my health information, as outlined above, to the clinic or doctor I have noted above.**

Signature: _____ Today's Date: _____

**Fred J. VonStieff, M.D. • Kristi M. Carpenter, D.O.**
2481 Pacheco Street, Concord, CA 94520 • Ph. (925) 680-8933 • Fax (925) 680-7635
Please visit us online at www.vsmedicalgroup.com