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: ____

Phone: ______________________ Fax: ______________________

Street Address: ____

City: ______________________ State: ________ Zip: ____________

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

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

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