HERITAGE
Sierra Medical Group

Dear Member,

The physicians and staff of Heritage Sierra Medical Group would like to take this opportunity to welcome you! We are pleased that you have selected us and look forward to serving your health care needs. The facilities at Heritage Sierra Medical Group are state-of-the-art and fully equipped with electronic medical records, on-site digital x-ray and laboratory services, with urgent care centers located in both facilities.

Member Services - (661) 273-7346

Palmdale

Clinic:	Monday - Friday	8am - 5pm
Urgent Care:	Monday - Sunday	8am - 8pm

Lancaster

Clinic:	Monday - Friday	8am - 5pm
Urgent Care:	Monday - Friday	8am - 8pm
	Saturday - Sunday	9am - 5pm

Santa Clarita

Clinic:	Monday - Friday	8am - 5pm

(Holiday hours may vary)

A physician is available by telephone after hours at (661) 273-7346.

Please complete the attached medical records release form and return to either address below.

Don't forget to call and schedule your new patient physical appointment today.

_____

Date Time

We look forward to having the opportunity and privilege of caring for you. Please feel free to contact our Member Services Department at (661) 273-7346 or via email at memberservices@sierramedicalgroup.com should you have any questions regarding our services.

Sincerely,

Tuan D. Phan, M.D.
Medical Director
Hertitage Sierra Medical Group

www. heritagesmg.com

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

(Request of PHI from another facility)

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this Authorization.**

PATIENT INFORMATION

Patient's Name: Last	First	Middle	Birth Date

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of protected health information about the above patient as follows:

Authorized to use or disclose information: (Name of person or organization you are requesting information from)			
Address	City	State	Zip Code

Authorized to Receive Information: (Name of person or organization who will receive the information)			
Address	City	State	Zip Code

DISCLOSE: ☐ All health information pertaining to any medical history, mental or physical condition and treatment received.

☐ Only the following records or types of health information: _____

_____

Dates of Service: ☐ All ☐ Specific dates: _____

Method of use or disclosure: ☐ mail ☐ pick up ☐ review/inspect ☐ fax to #_____ ☐ other _____

PURPOSE: The protected health information is being used or disclosed for the following purpose(s): ☐ Personal Use ☐ Continued Care

☐ Other _____

EXPIRATION: This authorization expires on (insert date or event): ☐ Date _____ ☐ Event _____

NOTICE OF RIGHTS AND OTHER INFORMATION

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address listed above.

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
I may refuse to sign this authorization.

I have a right to receive a copy of this authorization.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

NOTE: There may be a charge for copying services.

SIGNATURE

Date	Signature (Patient, Parent, Legal Guardian or Authorized Representative)	If other than patient, indicate relationship

Print Name	Address	Phone

Witness Signature	Print name and title	Date