SANTA ROSA SPORTS & Family MEDICINE

CONSENT TO RECEIVE CONFIDENTIAL PATIENT RECORDS

This will authorize: **Santa Rosa Sports & Family Medicine 1255 N. Dutton Ave Santa Rosa, Ca. 95401**
Phone: (707) 546-9400 Fax: (707) 546-9464

To receive the following information:

Check type | Signature | Date

- ☐ Medical Information _____ _____
- ☐ Psychiatric Information _____ _____
- ☐ Drug/Alcohol Information _____ _____
- ☐ Other - _____ _____

Regarding:_____DOB:_____

FROM: Facility/Organization/Individual _____

Address _____

City _____ State _____ Zip _____

Phone _____Fax _____

For the purpose of:_____

This consent will expire 1 year from the date signed.

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance hereon and if not revoked sooner in writing. I understand that this authorization is voluntary.

To the sending party of this information: This information has been requested of you for the sole purpose stated in this consent. Any other use of this information without the express written consent of the patient is prohibited. These records may be protected by Federal Regulation and HIPPA.

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

1255 N. Dutton Avenue Santa Rosa, California 95401 Phone (707) 546 - 9400 Fax (707) 546-9464