CONSENT TO RELEASE 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 release the following information:
Check type Signature Date

Medical Information _____ _____

Psychiatric Information _____ _____
Drug/Alcohol Information _____ _____
HIV Test/Treatment _____ _____
Genetic Information _____ _____

Regarding:_____DOB:_____

TO: 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