CONSENT TO RECEIVE CONFIDENTIAL PATIENT RECORDS

This form authorizes Santa Rosa Sports Medicine at 1255 N. Dutton Ave Santa Rosa, CA 95401 to receive the following information:

PLEASE CHECK ALL APPROPRIATE BOXES BELOW PROVIDE SIGNATURE OF THE PATIENT OR RESPONSIBLE PARTY

☐ Medical Information SIGNATURE ______________________ Date __ /__ /__

☐ Psychiatric Information SIGNATURE ______________________ Date __ /__ /__

☐ Drug/Alcohol Information SIGNATURE ______________________ Date __ /__ /__

☐ Other SIGNATURE ______________________ Date __ /__ /__

In regards to: PATIENT'S NAME ______________________ DOB: __ /__ /__

FROM: ______________________________________
FACILITY/ORGANIZATION/INDIVIDUAL

Street Address ______________ City ______________ State ____ Zip ________

Phone ( ) ______________ FAX ( ) ______________ Email ______________

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, CA 95401 | Phone (707) 546-9400 | FAX (707) 546-9464 | email: reception@srsportsmed.com