



CONSENT TO RELEASE CONFIDENTIAL PATIENT RECORDS

**This form authorizes Santa Rosa Sports Medicine
at 1255 N. Dutton Ave Santa Rosa, CA 95401
to release 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 ___ / ___ / ___
- HIV Test/Treatment SIGNATURE _____ Date ___ / ___ / ___
- Genetic Information SIGNATURE _____ Date ___ / ___ / ___

In regards to: PATIENT'S NAME _____ DOB: ___ / ___ / ___

TO: _____
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 ___ / ___ / ___

