



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
<input type="checkbox"/> Medical Information	_____	_____
<input type="checkbox"/> Psychiatric Information	_____	_____
<input type="checkbox"/> Drug/Alcohol Information	_____	_____
<input type="checkbox"/> Other - _____	_____	_____

Regarding: _____ DOB: _____

FROM: _____
 (Facility/Organization/Individual receiving information)

 (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 receiving 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 expressed written consent of the patient is prohibited. These records may be protected by Federal Regulation and HIPPA.

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

