CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION TO A DESIGNATED PATIENT REPRESENTATIVE

Patient Name: _____ MRN: _____

Address: _____ Record Base #: _____

City, State _____ Zip: _____

To be completed by Patient

I, _____, hereby authorize my provider,
Print Patient's Name

_____, at Sansum Clinic to release protected health
Print Provider Name

information regarding me or my condition/treatment _____ to:

_____ my _____
Print Name of Representative Relationship to Patient

_____ my _____
Print Name of Representative Relationship to Patient

_____ my _____
Print Name of Representative Relationship to Patient

_____ _____
Patient's Social Security Number Patient's Date of Birth

_____ _____
Signature of Patient Date Signed

_____ _____
Signature of Witness Date Signed

NOTE TO PATIENT: For confidentiality reasons we will ask your designated representative for the last four digits of your Social Security Number and for your date of birth.

Please return completed form to: _____ at Sansum Clinic
MSC/Name of Provider P.O. Box 1200
Santa Barbara, CA
93102

***Clinic Staff:* Forward original to HIS after documenting in IDX**