San Dimas Family Practice
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CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENTS PLEASE NOTE: PROTECTED HEALTH INFORMATION (PHI) MAYBE RELEASED IN ORDER TO CARRY OUT TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS ***(TPO)*** WITHOUT YOUR WRITTEN CONSENT. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS

Patient Name:_____ Date of Birth:_____
(Please Print Clearly)

With my consent, San Dimas Family Practice may release PHI about me by (a) calling my home or other designated location to leave a message on voice mail or in person, (b) by sending mail to my home or other designated location, or (3) by faxing to my home or other designated location.

Other designated location(s) or telephone / fax number(s):_____

_____

With my consent, San Dimas Family Practice may disclose Protected Health Information (PHI) about me to:

☐ Spouse:_____(name)

☐ Significant other:_____(name)

☐ Child/children:_____(name(s)

☐ Member(s) of my household:_____(name(s)

☐ Other:_____(name(s)

Signature:_____ Date:_____
Patient or guardian