Dignity Health Medical Group.
Sequoia
A Service of Dignity Health Medical Foundation

CONSENT TO RELEASE PERSONAL INFORMATION

DATE: ______________

PATIENT'S FIRST NAME:_________________________________

PATIENT'S LAST NAME:__________________________________

PATIENT'S DOB:_______________________

Due to our policy, and HIPAA regulations, Dignity Health Medical Foundation cannot disclose any medical information to family members and/or friends. If the patient chooses to designate a family member and/or friend to obtain personal information, Dignity Health Medical Foundation requires a signed consent form from the patient. In addition to the authorized person's name, relationship to the patient, date of birth, address and phone number, the patient will need to INDICATE EXACTLY what type of information can be provided.

DESIGNATED RECIPIENT OF PERSONAL INFORMATION

NAME: ____ DOB: ____________________

RELATIONSHIP TO PATIENT: ____

ADDRESS: ____

PHONE NUMBER(S): (CELL) _________________________ (H) _________________________

INFORMATION APPROVED TO RELEASE:

__________ ALL MEDICAL/BILLING INFORMATION

__________ ONLY THE FOLLOWING INFORMATION(S): ______________________________

____ ___________________________

PATIENT'S SIGNATURE **DATE**