Santa Rosa
MEDICAL GROUP

I, _____, do hereby give any physician, staff, employee or representative of Santa Rosa Medical Group my permission to discuss my account and medical conditions, which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information, excluding copies of my personal medical records, to the following person(s) in order to facilitate and coordinate my care, treatment and payment:

Name of Individual Receiving Info	Relationship/Phone Number
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I have been informed of the Privacy Act and I understand that Santa Rosa Medical Group will only be allowed to release information to the people listed above. I also understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Santa Rosa Medical Group or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s) it may be subject to re-disclosure by the individual(s).

Patient Signature: _____ Date: _____

Witness: _____ Date: _____