Associated Family Physicians
8110 Timberlake Ways, Sacramento, CA 95823
P: (916) 689-4111 F: (916) 689-6620
417 C Street, Gait, CA 95632
P: (209) 745-1778 F: (209) 745-9187

MRN: _____

HIPAA Consent

My Name: _____ **Date of Birth:** _____

I give permission to Associated Family Physicians to share my health information with the following person(s) so that this person(s) may assist me with my health care issues:

Name of person(s) who may receive information: _____

_____

☐ **Check here to allow our staff to leave detailed messages on your voicemail.**

Associated Family Physicians may share the information designated below with the above-named person(s) starting on today, _____ until I revoke this authorization.

I want Associated Family Physicians to share the following health information: (Check all that apply)

☐ All Health Information (Including the items below)

Or

☐ Information regarding prescription drugs
☐ Information regarding my lab results
☐ Billing information
☐ Scheduling information
☐ Other: _____

This form must be signed by the patient. The patient's parent or guardian may sign for the patient if he or she is a minor.

Signature of patient or representative: _____ **Date:** _____

You may revoke this authorization at any time by:

Mailing a written request to:
Associated Family Physician
Medical Records Department
8110 Timberlake Way
Sacramento, CA 95823

Faxing a written request to:
(916) 405-1409

Emailing a written request to:
medrec@familymd.com