Ridley-Tree Cancer Center | sansum CLINIC

Pt. Name_____

MRN: _____

Patient Consent to Disclose Protected Health Information (PHI) and Billing Information to a Designated Representative

_____ _____
Patient Name (*Please print*) MRN

_____ _____
Address DOB

_____ _____ _____
City State Zip

I hereby give consent to provider _____ (*name of provider*) to release protected health information (PHI) as indicated below to the following representative(s), outside requestor(s), and/or other provider(s).

Place check the information for requested disclosure:
_____Medical Information ONLY _____Billing Information ONLY _____Both medical and billing information
_____Other (Specify):_____

_____ Designated Representative Name	_____ Relationship to Patient	_____ Phone number	Yes No (circle one) Emergency Contact
_____ Designated Representative Name	_____ Relationship to Patient	_____ Phone number	Yes No (circle one) Emergency Contact
_____ Designated Representative Name	_____ Relationship to Patient	_____ Phone number	Yes No (circle one) Emergency Contact
_____ Designated Representative Name	_____ Relationship to Patient	_____ Phone number	Yes No (circle one) Emergency Contact

I understand:

- **This consent will expire in 24 months from the date of signature, unless I cancel it before that time. I can cancel this consent at any time by sending a written request to: Health Information Services, PO Box 62106, Santa Barbara, CA 93160.**
- **If I cancel the consent, it will NOT apply to information previously released with this consent. Once information is shared, this provider cannot prevent the person or organization that has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.**
- **I understand that I am not required to sign this consent and that this provider and its affiliates cannot base treatment or payment decisions based on my decision to sign this consent form.**

Signature: _____

Printed Name: _____ Date Signed _____

Relationship to Patient: _____

Reviewed by: _____ _____
Staff Name (Please print) Department