SAN BERNARDINO MEDICAL GROUP, INC.
Communication Consent Form

HIPAA (Health Insurance Portability and Accountability Act) is a federal law that protects personal medical information. The law also allows you to identify others you would like to include in receiving "General Medical Information" about your medical care. Please note that "General medical information" **does not include** the discussion of Psychiatric Services, Drug and Alcohol Counseling, Sexually Transmitted Diseases, HIV Testing, Pregnancy or Termination of Pregnancy.

If you give permission for San Bernardino Medical Group to release General Medical Information to anyone other than yourself please list them in the space below.

Name	Relationship	Phone #

TELEPHONE MESSAGES

Do you give San Bernardino Medical Group your permission to leave general medical information on your answering machine or voicemail? **Yes** **No**

PRESCRIPTION HISTORY RELEASE

Adverse Medication Reactions can occur when 2 or more physicians are ordering medications for the same patient.
Do you give San Bernardino Medical Group permission to request your prescription records from other pharmacies?
Yes **No**

APPOINTMENT

Appointment reminders are provided two days in advance for laboratory testing, radiology procedures and physician appointments. Please indicate your preference for these reminders by initialing the appropriate line.
You may check multiple options:

Phone Call ☐ Phone Number ____________________

Text Message ☐ Cell Number ____________________

Email ☐ Email Address ____________________

None ☐

PROVIDER ACCESS TO RECORDS

Outside providers that you have been referred to may have access to medical and administrative information that is used for patient care and billing purposes. If you would like to restrict outside provider access to your records please indicate only ONE of the following: **Disallow ALL outside access to my records:** ☐

Providers NOT allowed to access my records: ____

Restrict records access to ONLY these providers: ____

Print Patient Name Here	**Patient Date of Birth**
Signature of Patient / Parent / Legal Guardian	**Date**