SXM SYMPTOM MEDICINE
Pain Medicine, Palliative Care, Anesthesia

CHANTE S. BUNTIN, M.D.
824 Bay Avenue, Suite 70, Capitola, CA 95010
tel: 888.796.6331 fax: 888.796.6330

RELEASE OF PROTECTED HEALTH INFORMATION FROM SYMPTOM MEDICINE

Name _____ DOB_____ Age Sex _____ MR #_____

Your physician, whom has long term responsibility for your care, has referred you to Symptom Medicine for a consultation. Thus, it is important for the Clinic to have ongoing communication of our findings and your progress. Please Note: For Worker's Compensation of any kind, litigation of any kind, disability insurance, Social Security Administration, and managed care insurance companies, it may be required by law, bound by the undersigned's circumstances and/or insurance policy to communicate Patient care to the physicians, medical providers, agencies or insurance companies involved in the patient's case management and medical care.

I, _____, hereby consent and authorize the release of all medical records and health information held by Symptom Medicine in the provision of my care and services. This includes, but is not limited to laboratory studies, radiographic images, medications, psychological reports, mental health records, physician notes, evaluations, examinations, treatments, self determination forms (i.e. DNR/DNI, POLST, Health Care Directives, etc.) and/or procedures to my physicians and other relevant health care professionals participating in my care.

List your health care providers below

Specialty	**Provider Name**	**Address**	**Tel**	**Fax**
Primary Care M.D.				
Referring Provider				
Surgeon				
psychiatrist				
psychologist				
Lawyers				
WC Case Workers				
Pharmacy				

Starting from the date signed, unless I otherwise inform SXM in writing, this statement for the release of medical and protected health information from other facilities and/or providers to Symptom Medicine is valid for the duration I am a patient at Symptom Medicine. I authorization SXM to use a copy of this signed Release of Protected Health Information form when requesting medical information and records from my physicians and other relevant providers participating in my medical and mental health care.

Patient Signature	**Name:**	**Date and Time**
Patient Representative Signature	**Name: and Relationship**	**Date and Time**

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RELEASE OF PROTECTED HEALTH INFORMATION TO SYMPTOM MEDICINE

Name _____
Other Names Used _____
DOB_____ Age/ Sex _____
MR #_____
SS No._____

Faculty Requesting Health Information From
Name _____
Address_____
Tel _____
Fax _____

I, _____, hereby consent and authorize the release of all medical records and protected health information held by Symptom Medicine in the provision of my care and services. This includes, but is not limited to laboratory studies, radiographic images, medications, psychological reports, physician notes, evaluations, mental health records, examinations, treatments, self determination forms (i.e. DNR/DNI, POLST, Health Care Directives, etc.), and/or procedure to my physicians and other relevant health care professionals participating in my care.

Specific Instructions: _____
_____

Please fax or mail the copies to:

Symptom Medicine
824 Bay Ave., Suite 70
Capitola, CA 95010
Tel 888.SXM.MED1 (888.796.6331)
Fax: 888.SXM.MED0 (888.796.6330)

Starting from the date signed, unless I otherwise inform SXM in writing, the above statement for the release of medical and protected health information from other facilities and/or providers to Symptom Medicine is valid for the duration I am a patient at Symptom Medicine. I authorization SXM to use a copy of this signed Release of Protected Health Information form when requesting medical information and records from my physicians and other relevant providers participating in my medical and mental health care.

Patient Signature	Name:	Date and Time
Patient Representative Signature	Name: and Relationship	Date and Time

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ASSIGMENT OF PATIENT REPRESENTATIVE BY PATIENT

I_____ designate _____ as my patient representative also referred to as "Decision Maker". I give permission for the decision maker, the authority to act, to make medical decision, and to sign all of my medical documents on my behalf. The Decision Maker knows my desires and wishes, and will act in my best interest and for my welfare

By signing this form, the legally recognized decision maker acknowledges that the medical decisions are consistent with the known desires and wishes of, in the best interest of, and welfare of the patient named within.		
Patient Signature	Name: (First Last))	Date and Time
Patient Representative Signature	Name: (First Last) and Relationship	Date and Time
Witness Signature	Name: (First Last)	Date and Time

RELEASE OF PROTECTED HEALTH INFORMATION TO FAMILY/PATIENT REPRESENTATIVE

Name _____ DOB_____ Age Sex _____ MR #_____

I, the undersigned, hereby authorize Symptom Medicine to release my protected health information, verbally and in writing, regarding my care and/or status at SXM to the individuals listed below. I do not authorize the release of the following information. _____ Please note psychological reports will not be released to family members.

Name	**Relationship**	**address**	**Tel**	**Cell**
	DPOA			
	Lawyer			

Starting from the date signed, unless I otherwise inform SXM in writing, the above statement for the release of medical and protected health information to family/patient listed from Symptom Medicine is valid for the duration I am a patient.

Patient Signature	**Name:**	**Date and Time**
Patient Representative Signature	**Name: and Relationship**	**Date and Time**

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NOTORIZED CERTIFICATION FOR ASSIGMENT OF PATIENT REPRESENTATIVE BY PATIENT

I_____designate _____ as my patient representative also referred to as "Decision Maker". I give permission for the decision maker, the authority to act to make medical decision, and to sign all of my medical documents on my behalf. The Decision Maker knows my desires and wishes, and will act in my best interest and for my welfare. At any time, the patient with capacity, at anytime can void this assignment or change his/her mind about his/her treatment preferences by executing another notarized form

By signing this form, the legally recognized decision maker acknowledges that the medical decisions are consistent with the known desires and wishes of, in the best interest of, and welfare of the patient named within.		
Patient Signature	**Name: (First Last))**	**Date and Time**
Patient Representative Signature	**Name: (First Last) and Relationship**	**Date and Time**
Witness Signature	**Name: (First Last)**	**Date and Time**

NAME], _____ [ADDRESS. COUNTY, STATE];_____ Social Security Number _____ designate _____ presently residing at _____ as my attorney in fact (referred to as "the Agent") on the following terms and conditions: Powers of Agent. The Agent shall have the full power and authority to manage and conduct all of my affairs, and to exercise my legal rights and powers, including those rights and powers that I may acquire in the future, including the following:

Sign