**AZ Sports Medicine**

**Dr. Erik Dean & Dr. Amit Sahasrabudhe**

**Consent Form**

**Patient Name: Birth Date:**

Would you like a copy of the Notice of Privacy Practices? Declined [ ]  Accepted [ ]

**Acknowledgement of Notice of Privacy Practices:**

I have been offered a copy of the Notice of Privacy Practices. I understand that AZ Sports Medicine has the right to change its Notice of Privacy Practices from time to time and that I may contact AZ Sports Medicine at any time to obtain a current copy.

\*\*Signature: Date:

**I may be contacted in the following manner (circle all that apply):**

Ok to leave message with detailed information: Home Work Cell No

Ok to leave call back number only: Home Work Cell No

Ok to email to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization of Release of Health Information:**

I authorize the following individual(s) to have access to my personal health information.

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

\*\* Signature: Date:

**Workman’s Compensation,** if applicable

Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Claim #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Injury:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_Zip:

Adjuster: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:

Nurse Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: