Carmelo Plateroti
1101 Las Tablas Road, Suite G
Templeton, CA 93465
Phone: (805) 434-2821
Fax: (805) 434-2526

MEDICAL CARE RELEASE CONSENT

Patient Name: _____ Date of Birth: _____

I give permission to release medical information that may include but not limited to appointments, prescriptions, and test results to the following designated people. I understand that due to HIPAA guidelines, medical information will only be discussed with me and those listed below.

1._____ Relationship:_____ Ph#:_____

2._____ Relationship:_____ Ph#:_____

3._____ Relationship:_____ Ph#:_____

I give permission to have telephone messages left on answering machine: YES / NO

I give permission to have mail sent to my home address: YES / NO

I give permission to leave MESSAGES/CALL BACK NUMBERS at my work: YES / NO

Work #: _____

I give permission to have my records faxed wherever I choose at my request: YES / NO

SIGNATURE: _____ DATE: _____

MINOR PATIENT CONSENT:

I, _____, from this date forward give permission to Dr. Carmelo Plateroti's office to treat my son/daughter, _____ without the presence of a parent or guardian.

Signature: _____ Date: _____