91 Gregory Lane, Suite 13, Pleasant Hill, CA 94523
hello@calmedciti.com | (925)665-0008 | www.calmedciti.com

Patient's Name: _____ Date of Birth: _____

# Consent for Verbal Release of Information

Please document the preferred phone numbers to contact you, including the type of number and whether or not Selfcare by CalMedCiti employees can leave a detailed message. ***Please note: voicemail must have an identifying message to confirm these are your numbers. For example, "You have reached Mary Smith…"***

| Phone Numbers | Type | Can we leave a detailed message, including specific test result? |
|---|---|---|
| Primary: | ☐ Home<br>☐ Work<br>☐ Cell | ☐ Yes<br>☐ No |
| Secondary: | ☐ Home<br>☐ Work<br>☐ Cell | ☐ Yes<br>☐ No |

Please list any person(s) with whom we may share details about care, including billing information. Indicate whether this may include **S**ensitive **H**ealth **I**nformation **(SHI)** such as mental health, genetic testing, drug and/ or alcohol abuse treatment, and sexually transmitted diseases (STD) including HIV/AIDS

| Name | Relationship | Share SHI? |
|---|---|---|
| | | ☐ Yes<br>☐ No |
| | | ☐ Yes<br>☐ No |

With my signature below, I acknowledge and understand that this information will be kept in my medical records and the above parameters will be abided by until revoked by me writing. I understand that this consent applies to information about me obtained through any and all Selfcare by CalMedCiti and affiliates. I recognize that this is not consent for treatment and that I will not be able to revoke this consent in case where it has already been relied upon to disclose my health information. I acknowledge that it is my responsibility to notify my healthcare provider should I need to change any information listed above. I understand Pain Management Institute may ask me to update this form from time to time.

_____ _____

**Name over Signature of Patient/Legal Representative** **Date**

_____

**Relationship to Patient** ***(if signed by legal representative)***