S | V **Sierra Vista Internal Medicine**

I | M

Specialist in Adult Care

David J. Knapp, M.D.
Board Certified in Internal Medicine

PATIENT CONSENT FORM

Please list any family members or friends who may inquire about your healthcare. Information will not be provided to an individual unless his/her name appears on the list below.

PATIENT NAME: ____
(Last) (First) (MI)

ADDRESS: ____

PHONE: ________________________________**DATE OF BIRTH** ______________

I authorize SIERRA VISTA INTERNAL MEDICINE, PLLC to release:

___MEDICAL RECORDS/INFORMATION

___BILLING/INSURANCE INFORMATION

TO THE FOLLOWING PERSONS:

NAME: RELATIONSHIP:

____

____

____

____

____

Signature: ____________________________________ **Date:** __________________
(if under 18, Parent or Legal Representative)

75 Colonia De Salud Suite 200A • Sierra Vista, Arizona 85635 • Phone: 520-458-8145 • Fax: 877-771-1056