SMC
SARASOTA MEDICAL CENTER
4450 S. Tamiami Trail, Sarasota, FL 34231
Ph. 941-927-1234 Fax. 941-921-0043

Patient Consent for Receipt and Transmittal of Protected Health Information

DOES SARASOTA MEDICAL CENTER HAVE PERMISSION TO:

1. Mail notices to your home address: Yes No

2. Leave the following information on your **HOME/ CELL** voicemail:
   - Appointment Information Yes No
   - Billing Information Yes No
   - Medical Information Yes No
   - Prescription Refills Yes No
   - Authorizations or Referrals Yes No

3. Leave the following information on your **WORK** voicemail:
   - Appointment Information Yes No
   - Billing Information Yes No
   - Medical Information Yes No
   - Prescription Refills Yes No
   - Authorizations or Referrals Yes No

4. I give permission to Sarasota Medical Center to share appointment and billing information with the following people listed below:
   Name:_____ Relationship:_____
   Name:_____ Relationship:_____
   Name:_____ Relationship:_____
   Name:_____ _____Relationship:_____

5. I give permission to Sarasota Medical Center to share medical information with the following people listed below:
   Name:_____ Relationship:_____
   Name:_____ Relationship:_____
   Name:_____ Relationship:_____
   Name:_____ Relationship:_____

Patient Name (printed):_____ Date of Birth:_____
Patient Signature:_____ Date:_____
Guardian Signature: _____ Date:_____
(if patient is under 18 years old)