AZ Sports Medicine
Dr. Erik Dean, Dr. Amit Sahasrabudhe, & Dr. Stacey Dault
Consents Form

Patient Name: ____ Birth Date: __________________

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

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Acknowledgement of Notice of Privacy Practices:
I have been offered a copy of the Notice of Privacy Practices. I understand that AZSports Medicine has the right to change its Notice of Privacy Practices from time to time and that I may contact AZ Sports Medince 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:___________________