

JON J. ATIGA, M.D., INC.
27699 JEFFERSON AVE., STE. 314
TEMECULA, CA 92590

CONSENT TO SHARE/DISCUSS PRIVATE HEALTH INFORMATION

THIS FORM DOES NOT SERVE AS A MEDICAL RELEASE OF RECORDS

I _____ give consent for _____
Legal Guardian Name Person Full Name

to discuss with Dr. Jon Atiga and/or staff private health information regarding

Patient Name

I understand that this agreement does not serve as a medical release of records and that Dr. Jon Atiga and/or staff can refuse to discuss private health information if believed that it is in the best interests of the patient. This consent to share/discuss private health information with _____ is effective _____.
Person Full Name Date

Relationship between patient and authorized person is _____.

Legal Guardian Signature _____

Date _____