

**PAUL A. MIKEL MD**

**LINDA I. SODOMA DO**

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**480-668-4411**

## **Client/Patient Confidentiality**

I give my consent for my physician to view and maintain a copy of my Sure Scripts prescription history as part of my clinical medical record. I understand that this information will remain confidential and will not be transferred to outside entities without my written consent.

I also have received and understand the policies outlined in the HIPAA summary "Notice of Privacy Practices."

Please sign below

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Coordination of Benefits**

I currently am insured with \_\_\_\_\_  
Insurance company name

And I do not carry a secondary policy. **Or**

I carry secondary insurance coverage with \_\_\_\_\_  
Insurance company name

As of this date \_\_\_\_\_  
today's date

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Relationship to Patient

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