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