SADDLE ROCK INSTITUTE

Authorization to Disclose Patient Information

Patient
Name: _____
Date of Birth:_____
Address:_____
City:_____
State:_____
Zip:_____
Phone #:_____

Information to be Disclosed to:
Name: _____
Address:_____
City:_____
State:_____
Zip:_____
Phone #:_____
Fax #:_____
Email:_____

Information to be Disclosed/Released:
- ☐ Medical/Dental Information
  - Treatment Plan/Notes
  - Medical History
- ☐ Billing/Insurance Information

Information may be Released:
- ☐ During Patient Admission/Visit
- ☐ By Phone, Fax, or Email

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above via oral transmission. I understand that once this information is disclosed, it may no longer be protected. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization. I acknowledge that incomplete forms cannot be processed. I understand that this consent expires 180 days from the date of my signature unless otherwise specified as follows:

_____ I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy, fax, or scan of this form is to be considered as valid as the original.

Signature of the Patient/Authorized Representative:_____

Printed Name:_____

Date of Signature:_____

Relationship to Patient (if applicable):_____