SALINE
MEDICAL SPECIALTIES
969 East highway 33
Crete NE 68333
www.smscrete.com

Request for Sharing of Treatment/Billing Information

Patient Name: _____ Date of Birth: _____

Give permission for ***Saline Medical Specialties*** to share my individually identifiable health information with:

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____
3. Name: _____ Relationship: _____
4. Name: _____ Relationship: _____
5. Name: _____ Relationship: _____

***Your provider may choose to share protected health information with others that are not listed above as necessary to coordinate and facilitate your care.**

Messages

If unable to reach me:

- ◯ You may leave a detailed message regarding my medical care
- ◯ Leave a message asking me to return your phone call
- ◯ DO NOT LEAVE A MESSAGE

It is okay to leave a message on:

- ◯ Home Phone
- ◯ Work phone
- ◯ Cell Phone

Signature: _____ **Date:** _____

Relationship: _____

Updated 04/2019