



# 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:** \_\_\_\_\_