Silver Sage Center
For Family Medicine

Dr. Teresa Angermann
Dr. Andrew Pasternak

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(775) 853-9394 (775) 853-3339 Fax

ATTN: Medical Records

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name: ______________________ DOB: __________

Phone #: ______________________ SS #: ______________________

PLEASE OBTAIN INFORMATION FROM:

____
Name of Provider/Clinic/Organization

____
Street Address

____
City, State, Zip Code

Phone: __________ Fax: __________

PLEASE OBTAIN INFORMATION FROM:

____
Name of Provider/Clinic/Organization

____
Street Address

____
City, State, Zip Code

Phone: __________ Fax: __________

I AUTHORIZE the following information to be disclosed: (Please initial all that apply)

_____Entire Record
_____Immunization Record
_____TB Test
_____Other Record ______________________
_____Diagnostics
_____Alcohol/Substance Use

REASON for disclosure of health information: (Please Initial)

_____Patient Request
_____Legal
_____Job/School
_____Continuing Care
_____Insurance
_____Other

EXPIRATION of this Authorization: (Please initial one)

_____90 Days after signing
_____On this Date______________________

ADDITIONAL PATIENT INFORMATION:

- I understand that I do not have to sign this authorization to get treatment.
- I understand that once my health care information is disclosed as I have authorized, it could be rediscover by the recipient and is no longer protected by Silver Sage Medical Clinic.
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

______________________ Date: ________
Patient Signature

____
Name of Provider/Clinic/Organization

☐ Pick-Up Records ☐ Mail Records ☐ Fax Records

Completed By: ______________
Date: ______________