



Anita Sadaty, MD  
*Redefining Health*

## CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I \_\_\_\_\_ hereby give consent and authorize  
Dr. Anita Sadaty and her office staff to disclose personal health information  
to: \_\_\_\_\_

(Name of Person/Agency Requesting Information)

How may this information be released? Please choose all that apply:

Verbally  Photocopy

### Client/Patient:

Full Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Witness:

Full Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

