



Disclosure and Consent Form

Patient Name _____

_____ I authorize the specified information below to be disclosed to the specified individuals below.

Name: _____ Relationship: _____

- ☐ Financial Information: _____
- ☐ Medical Information: _____

Name: _____ Relationship: _____

- ☐ Financial Information: _____
- ☐ Medical Information: _____

Name: _____ Relationship: _____

- ☐ Financial Information: _____
- ☐ Medical Information: _____

This authorization will expire 2 years from today. I have the right to revoke this authorization at any time by stating in writing and sending my written revocation to Oasis Mental Wellness, PLLC

Expiration Date: _____



_____ I DO NOT authorize my health information to be shared with anyone other than my insurance company. My refusal will not affect my ability to obtain healthcare treatment, payment or eligibility for benefits.

Regarding Messages

_____ I authorize you to leave a detailed message on my home or cell number regarding appointments

Patient Name/Signature (or Guardian)

Patient Date of Birth

Date

If patient has a legal guardian – name of responsible party, relationship to patient, signature and date