Dr. Tatiana Sadak
PhD.PMHNP.ARNP
Psychiatric Wellness and Dementia Care, LLC

I understand that my healthcare information at PWDC, LLC is protected and I have reviewed a Notice of Privacy Practices.

The names(s) listed below are family members or friends to whom I wish to grant access to my health care information (to include verifying appointment dates and times). I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem necessary.

☐ Information may be left on answering machine, by email or by other electronic means at providers discretion.

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

NAME **RELATIONSHIP**

1._____ _____

2._____ _____

3._____ _____

Patient Name_____ DOB_____
(Print)

Patient Signature_____ Date_____

Witness Signature_____ Date_____

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