GEARY COMMUNITY HOSPITAL
RURAL HEALTH CLINICS

Patient Name (print): _____ DOB: _____

INFORMATION RELEASE FORM

- List the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care options):

  Name _____ Relationship _____ DOB _____ Phone _____

  Name _____ Relationship _____ DOB _____ Phone _____

  Name _____ Relationship _____ DOB _____ Phone _____

- List the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

  Name _____ Relationship _____ DOB _____ Phone _____

  Name _____ Relationship _____ DOB _____ Phone _____

  Name _____ Relationship _____ DOB _____ Phone _____

- If patient is a minor, please list any family members or other persons, if any, whom may give general consent for treatment:

  _____ _____

  _____ _____

  _____ _____

- **Print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information IF OTHER than your primary phone number:**

  _____

  I am fully aware that a cell phone is not a secure and private line.

- Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

  Yes ☐ No ☐

- Can this office contact you via e-mail? Yes ☐ No ☐

  If yes, please list e-mail address: _____

- This information will be in effect until revoked or new form completed.

_____ _____

PATIENT/GARDIAN SIGNATURE Date

Updated 10/04/2018