HASTINGS
Internal and Family Medicine

Family and Friends

_____

Patient Name Date of Birth

Please list your emergency contacts:

1. _____
   Emergency Contact Relationship Phone number (s)

   May we share your medical and mental health information with this person? ☐ Yes ☐ No

2. _____
   Emergency Contact Relationship Phone number (s)

   May we share your medical and mental health information with this person? ☐ Yes ☐ No

List any other people to whom we may disclose your medical and mental health information. This may include family or friends who call with questions about your care, or people with whom we may leave a message for you about your health:

_____
Name Relationship

_____
Name Relationship

_____
Name Relationship

- *The practice places no condition for treatment on completion of this authorization form.*
- *This authorization requires annual renewal at the first appointment of every calendar year. If not renewed, it will automatically expire after 3 years. It may be revoked at any time in writing by contacting Hastings Internal and Family Medicine.*

SIGNATURE:

_____

Authorized Signature **Printed name and relation to patient (if applicable)** **Date**