ST. MARY'S MEDICAL CENTER

HIMG
An outpatient facility of St. Mary's Medical Center
Member of MOUNTAIN HEALTH NETWORK

Date: _____

Patient Name: _____ Telephone #: _____

Patient Date of Birth: _____

Due to the HIPAA regulations, I hereby authorize the following names of those listed below to discuss and participate in my medical care (names of family members/friends who may be calling on your behalf; it is not necessary to list doctors' names.) I understand that if the names are not listed below, the office of St. Mary's HIMG, cannot release any information.

NAMES	RELATIONSHIP	TELEPHONE #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature: _____ Date: _____

Emergency Contact: Name: _____