Scenic Rivers
HEALTH SERVICES

Bigfork Clinic	Big Falls Clinic	Cook Clinic	Northome Clinic	Floodwood Clinic	Tower Clinic
218-743-3232	218-276-2403	218-666-5941	218-897-5222	218-476-2221	218-753-2405

DIRECTIVE OF PATIENT CARE
WITH FAMILY MEMBER OR APPOINTED PERSON

Authorization for family member or appointed person to discuss patient care and/or receive documentation of patient care from provider and/or staff member.

Patient Name: *(First, Middle, Last)* **Date of Birth:** _____

_____

1) Release Information To: (must be 18 years of age or older)

_____ Relationship to Patient**:** _____
_____ Relationship to Patient**:** _____
_____ Relationship to Patient**:** _____
_____ Relationship to Patient**:** _____

The individual named above is authorized to obtain information in the following manner:

- O Verbally: for example, via phone call or in person (face to face)
- O Written or printed format: for example, medical record copies or appointment/referral information
- O **Comment:**_____

_____

I understand the information to be released may include my past, present or future health information. I may revoke this authorization at any time. This authorization will not expire unless revoked by myself or my legal representative or upon notification of death.

_____ **Date:** _____
Patient's Signature

_____ _____
Authorized Person's Signature (if patient unable to sign) **Authorized Person's Authority To Sign (Parent, Guardian, Power of Attorney, Etc.)**

_____

2) Patient Message Authorization:
I authorize a medical related message to be left on my behalf on my phone's voice mail. A message will only be left if my name is identified on my voice mail message:

_____ **Date:** _____
Patient's Signature