Scenic Rivers Clinics

Bigfork Clinic	Big Falls Clinic	Cook Clinic	Eveleth Clinic	Northome Clinic	Floodwood Clinic	Tower Clinic
218-743-3232	218-276-2403	218-666-5941	218-471-1800	218-897-5222	218-476-2221	218-753-2405

AUTHORIZATION FOR 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)* **Birthdate:** _____

_____

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

_____ Relationship to Patient: _____ Phone Number:_____
_____ Relationship to Patient: _____ Phone Number:_____
_____ Relationship to Patient: _____ Phone Number:_____
_____ Relationship to Patient: _____ Phone Number:_____

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

1) Verbally; for example, via phone call or in person (face to face)
2) Written, printed or electronic format: for example, medical record copies or appointment/referral information

I authorize a medical related message to be left on my behalf on my phone's voicemail. A message will only be left if my name is identified on my voicemail message: ☐ **YES** ☐ **NO**

If there are any restrictions regarding information that should not be discussed or released to the family member or appointed person, the patient must indicate such restrictions here:

_____
_____
_____

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 my 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.)