HASTINGS
Internal and Family Medicine

Personal Contacts (requires signature)

_____

Patient Name Date of Birth

Please list all people with whom we may share your medical information. This may be family, friends or neighbors who call with questions about your health, or with whom we may leave a message in case of emergency.

1. _____
   Name Relationship Phone number (s)

2. _____
   Name Relationship Phone number (s)

3. _____
   Name Relationship Phone number (s)

4. _____
   Name Relationship Phone number (s)

5. _____
   Name Relationship Phone number (s)

This authorization requires annual renewal (initial and date) 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 by contacting Hastings Internal and Family Medicine.

SIGNATURE:

_____

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

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Telephone (269) 948-0078, Fax (269) 948-0099