Patient Name:Patient Date of Birth:					St Luke's UNIVERSITY HEALTH NETWORK  MEDICAL COMMUNICATION			
needs with my famil	listed below the	ow. This p	its affiliates ("St. Luke's") to discuss my health status, care, and this permission does not give the individuals named below any access to my medical records:  The permission does not give the individuals named below any access to my medical records:  The permission does not give the individuals named below any access to my medical records:					
I understand that in a professional medica permitted by law. I agree that St. Luke	l judgment to	o disclose my	health inf	formation	in emergencies			•
Home Phone:	□Yes	□No				······································		
St. Luke's may lea	1		☐Yes	□No				
Work Phone: St. Luke's may lea	☐ Yes ve a voicema	□ No ail message	 □ Yes	□No				
Cell Phone:	□Yes	□No						
St. Luke's may leave a voicemail message			□Yes	□No				
St. Luke's may leave a text message			☐Yes	□No				
Personal Email:	□Yes	□No						
Work Email:	□Yes	□No						
I agree to notify St. L	_uke's if any	of the informa	ation I prov	ided abov	e changes.			
I understand that the patient, Attn: Practice		15.0	5.		-		٠	
PATIENT SIGNATURE	PRINTED NAME				DATE	TIME		

AUTHORIZED PATIENT REPRESENTATIVE SIGNATURE PRINTED NAME

TIME

DATE