KALISPELL REGIONAL HEALTHCARE

I,_____ would like to give authorization to this facility to discuss my medical care with the following persons. I understand this authorization will stay in effect until I ask to have it removed in writing.

Individual(s) Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature _____ Patient DOB _____

Printed Name_____ Date/Time _____

Can we Leave a Message? Extended or Brief (E or B)

Home Phone _____ OK to Leave Message Y or N

Cell Phone_____ OK to Leave Message Y or N

Work Phone_____ OK to Leave Message Y or N