Mercy Family Health Center
Medical Safe Haven
Consent Form

As a participant in the Medical Safe Haven, a Mercy Family Health Center staff member may contact me to provide assistance that meets my needs and circumstances. I understand that this authorization is voluntary, and that I may revoke it at any time in writing. Signing this authorization does not affect my ability to obtain treatment at any Dignity Health hospital.

PT NAME: ______________________________________

DOB:_______/______/_____ **PRIMARY TELEPHONE #:** _____________________________________

____ _____________________________

SIGNATURE OR MARK OF INDIVIDUAL **DATE**

Authorization will expire in one year if not otherwise specified

TO BE COMPLETED BY CLINIC STAFF
STAFF NAME: ___________________________ **PHONE #:**__________________**DATE:**___/___/____
ROI MUST BE SIGNED, COMPLETED AND ENCLOSED WITH REFERRAL

SAMPLE