Name: ___________________________

DOB: ____________________________

MRN#: ___________________________

Who may we speak with?

This form will allow MAHEC to **discuss** your medical and financial information about the care and services you have received with individuals of your choosing. This form does not allow the listed individuals to obtain copies of your medical or financial information. **You may list up to three (3) individuals below OR choose not to list anyone. You can update this form at any time.**

Person #1 that we can speak with

Name: ____

Relationship: ___________________________ Phone #: _______________________

Person #2 that we can speak with

Name: ____

Relationship: ___________________________ Phone #: _______________________

Person #3 that we can speak with

Name: ____

Relationship: ___________________________ Phone #: _______________________

OR

☐ I do not wish to list anyone at this time.

____ ______________________
Signature of patient, parent, or legal guardian Date