NORTHFIELD HOSPITAL & CLINICS

Information Authorization

Patient's Name: _____ **Date of Birth:** _____

This will authorize Northfield Hospital & Clinics and Long Term Care Center (LTCC) to verbally discuss my medical information during my stay with:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

❑ May provide a verbal update to _____Nursing Home Staff.

Signature of Patient: _____

Date: _____

Northfield Hospital & Clinics

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