Telephone/Visitor Authorization Form

Patient Name:	Patient ID:

I hereby allow the following individuals to participate in visitation and or phone calls as indicated. I understand that it is my responsibility to provide these individuals with my patient identification number and I understand that without my patient identification number and without being listed on this form that visitation and/or phone calls will not be approved. This list can be updated at any time during my stay. Visitor identification (Photo ID) will be checked prior to visitation for visitors greater than age 18.

This form does not grant permission for release of information.

Information about your treatment will only be shared pursuant a signed authorization to release medical, mental health and addiction records.

I hereby allow the following individuals to participate in phone calls and/or visitation:

Date/ Time	Name	Relationship	Phone Number	Phone Calls	Visitation	Patient Initials	Staff Initials

Flowers and other deliverable arrangements are not accepted to protect patient confidentiality.

Signature of Patient/Guardian: ____Date/Time: ________________

Signature of Witness:____Date/Time: ________________

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