



0100000

PLACE LABEL HERE.  
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

*INPATIENT PSYCHIATRIC UNITS  
INFORMATION DISCLOSURE CONSENT*

**INFORMATION AND PHONE CALLS**

- No Restrictions
- I DO NOT want ANY information to be given out.
- I DO NOT want the following persons to be given ANY information about my stay on the Psychiatry Unit, including the information that I am a patient here.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VISITORS**

- No Restrictions
- I DO NOT want ANY visitors.
- Ask patient first
- I DO NOT want the following people to visit me. Anyone NOT listed below may be allowed to visit if they come during visiting hours:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IN CASE OF EMERGENCY, NOTIFY:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone no. \_\_\_\_\_ Work phone # \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE PATIENT OR AUTHORIZED REPRESENTATIVE (AR)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TIME

\_\_\_\_\_  
STAFF SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TIME

**INTERPRETER ATTESTATION (when applicable)**

Interpretation has been provided by

\_\_\_\_\_  
SIGNATURE OF INTERPRETER/CYRACOM ID#

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TIME