# 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**