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I understand that I have a right to spiritual counseling while a patient in the facility.

☐ **I DO NOT CONSENT** to the facility notifying any clergy of my presence in the facility.

(**NOTE:** I understand that if a member of the clergy identifies me by name and asks for my room / bed number, this information will be provided pursuant to the facility's general policy on release of patient information.)

☐ **I DO CONSENT** to the facility notifying my clergy of my presence in the facility as noted below:

Name of Clergy
Name of Church
Telephone No.

☐ **PLEASE CONTACT** the community clergy for religion _____.

(**NOTE:** If you do not have a specific clergy, the facility will contact the community clergy of the religion specified above.)

☐ **PLEASE CONTACT** the facility clergy (if applicable).

The undersigned certifies that he / she has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as his / her agent to execute the above.

Parent, Patient's Signature or Authorized Representative	Date	Time
Relationship to Patient	Interpreter, if utilized	
Witness' Signature	If Telephone Consent, Second Witness' Signature	

PAT #: CHART #:
ADMIT DATE: DOB:
SEX: AGE:
ATT. DR.:

Release of Information to Clergy
ADM-1702GHMS (7/06) Page 1 of 1

ORIGINAL – Medical Record COPY – Person who contacts Clergy
COPY – Patient

Patient Label