Authorization to Disclose Protected Health Information to Clergy

I, _____ (DOB_____, Last 4 numbers of SSN _____) authorize any doctor or health care provider in whose care I am under to discuss my to discuss my current condition, prognosis, and plan of care with clergy of St. Luke's Episcopal Church in Salisbury, North Carolina, if I am unable to do so. Furthermore, I request that the clergy be notified if my health is in serious decline and/or prayers at the time of death would be appropriate.

Should emergency pastoral attention be needed, the church phone number is 704-633-3221. If the office is not open, the recording will instruct you on how to be in touch with the clergy.

By signing this authorization, I understand and acknowledge the following:

1. I am signing this authorization voluntarily, and not as any condition of membership in the church.
2. I have a right to revoke this authorization by following the instructions at the bottom of this page.
3. Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.

Signature: _____

Date: _____

Witness: _____

Revocation: This authorization is valid until my death unless it is revoked before then in writing and sent to St. Luke's Episcopal Church, or by signing below.

By signing here I revoke this authorization. _____