Hugh Chatham Memorial Hospital
180 Parkwood Drive
Elkin, NC 28621
(336) 527-7000

Patient Sticker

Patient name: _____ Patient Date of Birth: _____

Authorization for Request of Protected Health Information

I do hereby consent and authorize Hugh Chatham Memorial Hospital and Affiliates, to disclose my COVID 19 results and any Out of Work forms to:

Family Physician or Practice Name:		Family Physician Phone:	
Family Physician Location:		Physician's Fax:	
Employer Name:		Employer Phone:	
Employer Location:		Employer Fax:	

Other: _____

Other: _____

I have been advised to follow the CDC guidelines for quarantine.

_____ Date: _____ Witness: _____

Patient Signature:

_____ Patient Identification _____

Signature or Parent/legal guardian/ authorized representative

CON 03 2020