



3012A

FACILITY DIRECTORY INFORMATION

When you become an inpatient, individuals you know such as family and friends may choose to call or visit with you while you are in the hospital. If someone calls to speak with you or comes to visit, we generally will provide information on how and where you can be reached in the hospital. For spiritual support when you are ill, we may provide general information to members of the clergy. This form tells you what information can be shared and what to do if you do not want this information shared.

When Someone Asks For You By Name

While an inpatient in our facility, we may disclose the following information to someone who asks for you by name:

- Your location in the facility (i.e., your room number)
- Your general condition (e.g., good, stable, serious)

For example, if a family member or friend calls to speak with you, and specifically mentions your name, we can let them know where you are in the facility.

If you do not want your location in the facility and general condition shared with someone that calls and asks for you by name, please initial the statements listed below.

_____ *I do not want my location in the facility shared with someone that calls and asks for me by name.*

_____ *I do not want my general condition shared with someone that calls and asks for me by name.*

_____ *Complete opt-out. By choosing this option, I understand the facility will be unable to confirm or acknowledge my admission or stay to someone calling and asking for me by name (including family and friends).*

Members of the Clergy

If you tell us your religious affiliation, the following information may be disclosed in response to requests from members of the clergy in the community:

- Your name
- Your location in the facility (i.e., your room number)
- Your general condition (e.g., good, stable, serious)
- Your religious affiliation

If you do not want community clergy to have this information, please initial the statement listed below.

_____ *I choose not to list my religious affiliation.*

Signature of Patient/Legal representative: _____ Date/Time: _____



LOMA LINDA UNIVERSITY
MEDICAL CENTER

FACILITY DIRECTORY INFORMATION

Original – Medical Records

Copy – Patient

116-3012A (4-03)

PATIENT IDENTIFICATION

Name:

Birthdate:

Medical Record #: