



RELEASE

Resident's Name _____

Apt. # _____ Telephone # _____

1. I hereby give permission to Daughters of Sarah Nursing Center to release my name to my place of worship.

Signature of resident or responsible party **Date**

Place of worship

Name of clergy (if known)

2. *(For Catholics only)*: I give permission to Daughters of Sarah Nursing Center to release my name to the Eucharistic Ministers for purposes of receiving Communion/Sacrament of the Sick.

Signature of resident or responsible party **Date**

3. Please DO NOT release my name to my place of worship.

Signature of resident or responsible party **Date**

4. I am not affiliated with any place of worship.

Signature of resident or responsible party **Date**