



PATIENT ID
HERE

PATIENT/FAMILY CONTACT LIST

Patient's Name: _____ DOB: _____

Contacts

People who have permission to receive detailed information about your care (PHI):

PRIMARY CONTACT

Name: _____	Phone Numbers
	Cell: _____
Relationship: _____	Home: _____
<input type="checkbox"/> Check here if you would like us to involve this person in discussions about your health care	Other: _____

SECONDARY CONTACT(S)

Name: _____	Phone Numbers
	Cell: _____
Relationship: _____	Home: _____
<input type="checkbox"/> Check here if you would like us to involve this person in discussions about your health care	Other: _____

Name: _____	Phone Numbers
	Cell: _____
Relationship: _____	Home: _____
<input type="checkbox"/> Check here if you would like us to involve this person in discussions about your health care	Other: _____

I decline to designate a representative at this time.

Comments/Other Information:

This form is effective upon execution and will remain in effect unless revoked by me.

Patient/Guardian Signature: _____ Date: _____ Time: _____

Relationship to Patient: _____