Swedish Medical Group

Part of NorthShore

Emergency Contact(s)

Patient Name: _____ Date of Birth: _____

Swedish Medical Group ask I provide emergency contact(s) information which will allow Swedish Medical Group providers and its staff permission to reach out to my emergency contact(s) on file in the event of an emergency and allows my emergency contact(s) to view and obtain Protected Health Information on my behalf. Swedish Medical Group strongly recommends I list a trusted person(s) as an emergency contact(s). I understand information disclosed to my emergency contact(s) on file may be subject to re-disclosure and *no longer protected by federal privacy laws under the Health Insurance Portability and Accountability Act.*

This authorization is valid for all Swedish Medical Group locations until revoked by me in writing by completing a *new Emergency Contact(s)* form in person at any Swedish Medical Group location.

Please Print Clearly:

Emergency Contact #1

Name of Person: _____ Relationship to patient: _____

Address: _____ Phone #: _____

Emergency Contact #2

Name of Person: _____ Relationship to patient: _____

Address: _____ Phone #: _____

Emergency Contact #3

Name of Person: _____ Relationship to patient: _____

Address: _____ Phone #: _____

Emergency Contact #4

Name of Person: _____ Relationship to patient: _____

Address: _____ Phone #: _____

I understand I am responsible for maintaining my emergency contact(s) up to date and agree to report changes immediately. Patient, parent or legal guardian can view this form upon request.

X_____ _____ _____

Patient/Parent or Legal Guardian Signature | Relationship to Patient | Date

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Office Use Only: Contacts Updated

Staff Name:_____ Date:_____