CancerCare NORTHWEST™

Patient Contacts

By my signature below, I understand that the purpose of this form is to provide the contact names of people I have authorized Cancer Care Northwest (CCNW) to speak with regarding my medical condition. I also agree to keep this list current by informing CCNW immediately of any changes.

PRIMARY CONTACT: This is someone with whom you are in regular communication and with whom you are comfortable to receive more general information from CCNW about you. This may include, but is not limited to, PHI such as appointments, general health, prescriptions, transportation, and provider phone messages. Further restrictions on your PHI must be specified by you.

EMERGENCY CONTACT: This is someone you want called immediately to respond and assist you in case you are injured or otherwise incapacitated. This individual may be called in an emergency situation and therefore may receive your entire PHI. An emergency contact may also be a primary contact listed above or next of kin below.

NEXT OF KIN: These are generally your closest living relatives. By listing next of kin here, you agree that they are entitled to receive your PHI in the event of your incapacitation or death. Next of kin may also be listed as either a primary contact or emergency contact above.

ADDITIONAL CONTACT: This indicates you are adding this person to your established list of contacts.

Please Print:

Contact Type:	☐ Primary	☐ Emergency	☐ Next of Kin	☐ Additional contact
Contact Name			Relationship	Phone Number
Contact Type:	☐ Primary	☐ Emergency	☐ Next of Kin	☐ Additional contact
Contact Name			Relationship	Phone Number
Contact Type:	☐ Primary	☐ Emergency	☐ Next of Kin	☐ Additional contact
Contact Name			Relationship	Phone Number
Contact Type:	☐ Primary	☐ Emergency	☐ Next of Kin	☐ Additional contact
Contact Name			Relationship	Phone Number
Contact Type:	☐ Primary	☐ Emergency	☐ Next of Kin	☐ Additional contact
Contact Name			Relationship	Phone Number

Patient Signature *Account Number* *Date*

Patient Printed Name *Patient Date of Birth*

Personal Representative Signature *Relationship* *Date*

[Please provide CCNW with documentation of your legal representation on behalf of the patient (e.g., court order, DPOA , certificate of guardianship, living will, etc.)

For partial or comprehensive releases of your medical records (e.g., to an attorney, in printed format, for your own purposes, etc.), you must complete the appropriate ***Release of Information*** (ROI) form.

If you wish to restrict access to your health information, you must complete a ***Restriction Request*** form.

(Both forms are available at our reception desk.)

Employee Initials: ____________ Date:__________ Revised: *1/7/2019*