

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:	<input type="checkbox"/> Primary	<input type="checkbox"/> Emergency	<input type="checkbox"/> Next of Kin	<input type="checkbox"/> Additional contact
_____	_____	_____	_____	_____
Contact Name	Relationship	Phone Number		
Contact Type:	<input type="checkbox"/> Primary	<input type="checkbox"/> Emergency	<input type="checkbox"/> Next of Kin	<input type="checkbox"/> Additional contact
_____	_____	_____	_____	_____
Contact Name	Relationship	Phone Number		
Contact Type:	<input type="checkbox"/> Primary	<input type="checkbox"/> Emergency	<input type="checkbox"/> Next of Kin	<input type="checkbox"/> Additional contact
_____	_____	_____	_____	_____
Contact Name	Relationship	Phone Number		
Contact Type:	<input type="checkbox"/> Primary	<input type="checkbox"/> Emergency	<input type="checkbox"/> Next of Kin	<input type="checkbox"/> 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.)		

The below are related forms that you may request at any CCNW front desk:

- 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.
- To delegate a **healthcare proxy** (a person you trust to act on your behalf in the event of a serious injury or illness) please request further information at the CCNW front desk.

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EPIC BARCODE