



Patient's Contact List - HIPAA & Emergency Contacts

Date: _____ MRN: _____

Patient Date of Birth: _____

Legal Patient Name: _____

You have the option to select different types of contacts. You can designate one person to be both a HIPAA and Emergency Contact, but you also can designate separate people as either a HIPAA Contact or Emergency Contact.

A HIPAA contact is a person who you authorize Arizona Blood and Cancer Specialists to release information to about your medical condition. Any physicians who provide medical care to you don't need to be listed as HIPAA contacts.

It is important for you to name an Emergency Contact. This is a person that you authorize our staff to contact in the event you have a medical emergency while being treated in our office.

		Type of Contact:	
Contact Name:			<input type="checkbox"/> HIPAA <input type="checkbox"/> Emergency
Phone Number:		Other Phone:	
Relationship:			

		Type of Contact:	
Contact Name:			<input type="checkbox"/> HIPAA <input type="checkbox"/> Emergency
Phone Number:		Other Phone:	
Relationship:			

		Type of Contact:	
Contact Name:			<input type="checkbox"/> HIPAA <input type="checkbox"/> Emergency
Phone Number:		Other Phone:	
Relationship:			

____ I understand that I am authorizing Arizona Blood and Cancer Specialists, PLLC to disclose my personal health information to the individual(s) named above whom I have identified as my HIPAA contact(s).

____ I acknowledge that I have received a copy of Arizona Blood and Cancer Specialists, PLLC's Privacy Practices.

____ I acknowledge that I have the right to change contacts on this list at any time; that I can re-designate the Type of Contact originally stated; and that I have the right to revoke this contact list.

____ I acknowledge that any revocation of this list must be made in writing.

____ I have read this form, or had it read to me and I understand the consequences of my choices.

____ I understand that refusal to sign this authorization will not impact my ability to obtain care from Arizona Blood and Cancer Specialists, PLLC.

Patient Signature: _____ **Date / Time** _____ (select one) AM PM
(or authorized representative)

Physician: _____ Employee Initials: _____ Rev. 08/2019KR