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.

_______________________________________ _______________________ ______________
Patient/Parent or Legal Guardian Signature Relationship to Patient Date

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Office Use Only: Contacts Updated

Staff Name:____ Date:______________________