United Community Health Center
Patient Emergency Information & Consent Form
(Please Print)

Medical Record #: _____

Legal Name: _____
(last) (First) (MI)

EMERGENCY CONTACT PERSON: (preferably someone outside of the home)

Name: _____Relationship: _____Phone: _____

Make this emergency contact HIPAA Authorized: ◯ **Yes** ◯ **No** **Initial: _____**

Name: _____Relationship: _____Phone: _____

Make this emergency contact HIPAA Authorized: ◯ **Yes** ◯ **No** **Initial: _____**

Emergency contacts are NOT authorized to discuss healthcare information unless they are listed below, or marked as HIPAA authorized above.

AUTHORIZATION TO DISCUSS HEALTH INFORMATION:
In a non-emergent/or emergent situation, a UCHC staff member may discuss, or distribute in writing, my health information, to include lab results, radiology results, medication, and medical condition to the individual(s) listed below.

INITIAL EACH CONTACT

Name: _____Relationship: _____Phone: _____
Initial: _____

Name: _____Relationship: _____Phone: _____
Initial: _____

Name: _____Relationship: _____Phone: _____
Initial: _____

Signature:_____ Date:_____
(Month) (Day) (Year)

◯ **Patient** ◯ **Parent** ◯ **Guardian** ◯ **Other_____**