Abide Health Medical APC

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Emergency Contact Information Form

This form allows the **Abide Health Medical APC** to maintain emergency contact information for the undersigned patient (the "Patient"). The information provided here will be used only in case of emergency or when necessary for treatment coordination and in accordance with applicable privacy laws, including **HIPAA** and **Nevada state law**.

Please complete the following information so we can reach someone in case of an emergency.

Emergency Contact Information

Please provide at least one emergency contact, and include the relationship to the Patient. This information will only be used in the event of an emergency or as required by law.

Primary Emergency Contact:

Name of Contact: _____ **Relationship to Patient:** _____

Phone Number (Cell/Home/Work): _____ **Alternate Phone Number (if applicable):** _____

Email Address (optional): _____ **Physical Address (optional):** _____

Secondary Emergency Contact (if applicable):

Name of Contact: _____ **Relationship to Patient:** _____

Phone Number (Cell/Home/Work): _____ **Alternate Phone Number (if applicable):** _____

Email Address (optional): _____ **Physical Address (optional):** _____

Consent for Emergency Contact

I authorize the following individual(s) to be contacted in case of an emergency or urgent situation where I am unable to be reached. I understand that this information will only be shared with individuals listed above in emergency situations or as allowed under applicable privacy laws.

I acknowledge that providing emergency contact information is voluntary, but it is strongly recommended for my safety and well-being.

Acknowledgment

- I understand that this information is confidential and will be protected in accordance with **HIPAA** and **Nevada state law**.
- I acknowledge that I have provided accurate contact information to the best of my knowledge and that I will notify the Clinic of any changes to this information.

Patient Signature: _____ **Printed Name:** _____

Date: ___ / ___ / _____

Signature of Parent/Guardian: _____ **Printed Name of Parent/Guardian:** _____

Relationship to Patient: _____ **Date:** ___ / ___ / _____