Primary
Care Partners
Affiliated with
Atlantic Health System

PATIENT ID HERE

PATIENT/FAMILY CONTACT LIST

Patient's Name: _____ DOB: _____

Contacts

People who have permission to receive detailed information about your care (PHI):

PRIMARY CONTACT

Name:

Relationship:

☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers

Cell: _____ _____ _____

Home: _____ _____ _____

Other: _____ _____ _____

SECONDARY CONTACT(S)

Name:

Relationship:

☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers

Cell: _____ _____ _____

Home: _____ _____ _____

Other: _____ _____ _____

Name:

Relationship:

☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers

Cell: _____ _____ _____

Home: _____ _____ _____

Other: _____ _____ _____

☐ **I decline to designate a representative at this time.**

Comments/Other Information:

_____

_____

_____

_____

This form is effective upon execution and will remain in effect unless revoked by me.

Patient/Guardian Signature: _____ Date: _____ Time: _____

Relationship to Patient: _____