center for Human Development

Disclosure or Notification to Family or Others

PURPOSE: This form is used to identify the family members, close friends, and other persons to whom we may disclose protected account or appointment information about you (the client), or to contact in case of an emergency. This form is effective for the duration of your care or until you provide further notice.

SPECIAL INSTRUCTIONS: A minimum of one Emergency Contact person is required. Also, if the client named below is under 18, a parent or legal guardian must complete this form.

REQUIRED

CLIENT NAME	
EMERGENCY CONTACT	TELEPHONE
RELATIONSHIP TO CLIENT	ADDRESS
☐ ACCOUNT (OPTIONAL) ☐ APPOINTMENT (OPTIONAL)	

In addition to my required Emergency Contact person, I agree that protected account and/or appointment information may be disclosed to the additional person(s) listed. You may wish to include any of the following: a spouse (not automatically included), parent, other friend or relative, the insurance subscriber (this is the policy holder, not the insurance company), legal guardian, etc.

OPTIONAL

NAME	TELEPHONE
RELATIONSHIP TO CLIENT	ADDRESS
☐ ACCOUNT ☐ APPOINTMENT ☐ EMERGENCY CONTACT	
NAME	TELEPHONE
RELATIONSHIP TO CLIENT	ADDRESS
☐ ACCOUNT ☐ APPOINTMENT ☐ EMERGENCY CONTACT	
NAME	TELEPHONE
RELATIONSHIP TO CLIENT	ADDRESS
☐ ACCOUNT ☐ APPOINTMENT ☐ EMERGENCY CONTACT	

REQUIRED

____ ____________________
Client Signature (if 18 or older), or Parent/Legal Guardian (if client is under 18) Date

____ ____________________
Printed Name of Signature Above Relationship to Client

Retain this form in the Client's health information record

UPDATED: 7/14/2011 LDK