NEPHROLOGY ASSOCIATES OF SYRACUSE, PC

Philip T. Ondocin, MD
Matthew G. Chaffin, MD
Simardeep S. Mangat, MD
Bala K. Murthy, MD
Antoine Azar, MD

Marcia H. Ryder, RN, NP
Jacquelyn A. Spencer, RN, NP
Alyssa C. Miles, PA
Tracy A. O'Neill, PA
Maureen Lupica, NP
Hannah Huang, PA

Anne E. Zaccheo, MBA, FACMPE
Practice Director

HIPAA EMERGENCY CONTACT PATIENT CONSENT FORM

Patient Full Name: _____

Patient Date of Birth: _____

The physicians and providers of this practice will speak directly to each patient to ensure the integrity of the medical and legal rights of the patient. In compliance with HIPAA and Patient Privacy Laws, each patient may authorize an Emergency Contact(s) if desired in the event the patient is unable to communicate. It is imperative that each patient authorize a dependable and accessible emergency contact.

Emergency Contact / Authorized Individual(s): I authorize NAS to record and maintain the name(s) and phone number(s) of the emergency contact(s) and/or individual(s) with whom information may be shared in my medical record. I understand that it is my responsibility to notify NAS of any changes and to keep this information current.

Emergency Contact / Authorized Individual(s):

NAME **RELATIONSHIP** **CELL PHONE**
NAME **RELATIONSHIP** **CELL PHONE**

Signature of Patient :_____
or
Signature of Patient Legal Representative: _____