



KC Medical Care  
8101 College Blvd,  
Overland Park, KS 66210  
Fax: 913-912-7374

## Primary Care Provider Designation Form

### Patient Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Primary Care Provider Designation

I, \_\_\_\_\_ (patient or legal representative), designate  
**Dr. Nelopher Hathiary** of KC Medical Care as my (or the patient's) Primary Care Provider (PCP).

I understand that this designation allows Dr. Hathiary and KC Medical Care to provide and coordinate routine medical care, communicate with facility staff, and access medical information as needed for treatment.

This designation remains in effect until I revoke it in writing.

### **Patient or Legal Representative**

Name: \_\_\_\_\_

Relationship to Patient (if applicable): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Physician Acknowledgment (optional)**

I, **Dr. Nelopher Hathiary**, accept the designation as Primary Care Provider.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_