INVOLVEMENT IN CARE

Patient's Name _____ Date of Birth_____

Last Four Digits of Social Security Number _____

I agree that any TriHealth Affiliated Physician Practice ("Healthcare Provider") where I am a patient may disclose my protected health information ("PHI") at anytime to the following individual(s) who are involved in my care:

Name _____ Name _____

Address _____ Address _____

Telephone _____ Telephone _____

Relationship to Patient _____ Relationship to Patient_____

I acknowledge the following statements: The individual(s) named above are involved in my healthcare or its payment; All of my PHI is relevant to the specified individual(s) for my care or payment; and I agree that my Healthcare Provider may disclose my PHI to the individual(s) specified above.

I understand that disclosure of my PHI will include information on drug or alcohol treatment, abuse or conditions, and/or psychiatric or psychological conditions or treatment, and/or HIV related conditions, if any and agree to release of this information.

I understand that if at any time I no longer want Healthcare Provider to communicate with the individual(s) specified above, I will immediately notify them in writing by sending a letter to my Healthcare Provider's office.

I understand that Healthcare Provider may verify the identity of the individual(s) named above prior to disclosing any of my PHI. I also understand and agree that nothing in this request for involvement is intended to limit or alter Healthcare Provider's ability to disclose PHI to individuals not listed on this form in accordance with professional judgment and applicable law.

CONTACT INFORMATION FOR PHONE CALLS

Preferred contact number: □ Home □ Cell □ Work _____

Check your preferences below:

You may leave PHI on my answering machine/voice mail □Yes □No

You may leave PHI with an adult who answers my home phone □Yes □ No

You may leave the following: □ Test or lab results □ Appointment information □ Detailed message

□ A response to my inquiry or questions

□ **I DO** wish to specify any individuals with whom my Healthcare Provider may share my PHI.

_____ _____

Signature Date

□ **I DO NOT** wish to specify any individuals with whom my Healthcare Provider may share my PHI.

_____ _____

Signature Date