

INVOLVEMENT IN CARE

Patient's Name: _____ Date of Birth _____

Parent/Legal Guardian Name(s) if applicable. Please list all: _____

Email Address: _____

Preferred contact number: ☐ Home ☐ Cell ☐ Work _____

In addition to those listed above, would you like to designate another individual(s) to be involved in your/the patient's care?

_____ Yes (complete Section I and II) _____ No (complete Section I only)

SECTION I:

Healthcare Provider may leave the following protected health information ("PHI") on my answering machine/voicemail: test or lab results, appointment information, detailed message, response to inquiry/message: Yes _____ No _____

Healthcare Provider may leave PHI with any adult who answers my home and/or cell phone: Yes _____ No _____

SECTION II:

I agree that any TriHealth, Inc. or affiliated provider ("Healthcare Provider") may disclose my/the patient's PHI and billing information (if specified) at any time to the following individual(s):

Name _____

Name _____

Address _____

Address _____

Telephone _____

Telephone _____

Relationship to Patient _____

Relationship to Patient _____

Can Receive Billing Information: ☐ Yes ☐ No

Can Receive Billing Information: ☐ Yes ☐ No

I acknowledge the following statements:

- The individual(s) named above are involved in my/the patient's healthcare or its payment; All of my PHI is relevant to the specified individual(s) for care or payment; and I agree that the Healthcare Provider may disclose my/the patient's PHI to the individual(s) specified above.
- I understand that disclosure of my/the patient's 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.
- This form does not expire for patients aged 18 years and over. For minors, this form will auto-expire when the patient reaches the age of 18. I understand 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 the 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/the patient's 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.

Healthcare Provider may leave the following PHI on the above designated individual(s)' answering machine/voicemail:

Signature of Patient or Parent/Legal Guardian

Date