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

Name _____
Address _____
Telephone _____
Relationship to Patient _____
Can Receive Billing Information: □ Yes □ No

Name _____
Address _____
Telephone _____
Relationship to Patient _____
Can Receive Billing Information: □ Yes □ No

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.
- This form does not expire for patients age 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 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.

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 (check all that apply):

□ Test or lab results □ Appointment information □ Detailed message □ Response to my inquiry or questions

_____ _____
Signature of Patient or Parent/Legal Guardian Date

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

_____ _____
Signature of Patient or Parent/Legal Guardian Date