Involvement in Care

Patient's Name: _____ Date of Birth: _____

Last Four Digits of Social Security Number _____

I AGREE THAT ANY PHYSICAN AFFILIATED WITH FAMILY FOOT & ANKLE CENTER MAY DISCLOSE MY PROTECTED HEALTH INFORMATION ("PHI") AT ANYTIME TO THE FOLLOWING INDIVIDUALS(S) WHO ARE INVOLVED IN MY CARE:

Name: _____ Name: _____

Telephone: _____ Telephone: _____

Relationship to Patient: _____ Relationship to Patient: _____

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

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 this 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 Providers 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 judgement and applicable law.

CONTACT INFORMATION FOR PHONE CALLS

Check your preferences below:

Preferred contact number: _____ ☐ Home ☐ Cell ☐ Work

You may leave PHI on my answering machine/voice mail? ☐ YES ☐ NO

Patient/Guardian/Parent signature: _____ DATE: _____

FOR GUARDIANS OR PARENTS OF MINORS ONLY:

May we fax your child(ren)'s personal health information (such as shot records or required medical information) to his/her school or day care facility, when requested. ☐ YES ☐ NO Fax # _____