TriHealth Women's Services
Northeast

REQUEST FOR INVOLVEMENT IN CARE

Patient's Name: _____

Date of Birth: _____

Last four digits of Social Security Number: _____

I, _____ **[print your full name] (the "Patient"),** agree that TriHealth Women's Services Northeast ("Health Care Provider") may disclose my protected health information as described below:

The individual(s) listed below is/are involved in the care received by me as a patient of Health Care Provider:

Name: _____ Name: _____

Address: _____ Address: _____

Telephone number: _____ Telephone number: _____

Relationship to Patient: _____ Relationship to Patient: _____

I acknowledge that the individuals that I have specified above are involved with my health care and/or payment related to my health care. I acknowledge that all of my protected health information ("PHI") maintained by Health Care Provider is relevant to the above specified individual's (or individuals') involvement with my care or payment of that care. I agree to the disclosure of any and all of my protected health information by Health Care Provider to the individual(s) that I have specified above.

I further agree to the release of information to the individual(s) named above concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological condition and/or psychiatric/mental health treatment and/or HIV related conditions if any such information is contained in my protected health information.

I agree that if at any time, I no longer want Health Care Provider to communicate with the individual(s) specified above, I will immediately notify Health Care Provider in writing by sending a letter to the address of 11135 Montgomery Road, Cincinnati, Ohio 45249 addressed to medical records.

I understand that Health Care Provider may use any measures it deems appropriate to verify the identity of the individual(s) named above prior to disclosing any of my protected health information. I also understand and agree that nothing in this request for involvement in care is intended in any way to limit or alter Health Care Provider's ability to disclose my protected health information to individuals/entities not listed on this form in accordance with applicable law and professional judgment.

_____ _____, 20__.
Signature of Patient / Date

IF PATIENT DOES NOT WISH TO SPECIFY ANY INDIVIDUALS WITH WHOM HEALTH CARE PROVIDER MAY SHARE PHI, PLEASE CHECK THE BOX BELOW AND SIGN:

☐ I do not wish to specify any individuals with whom Health Care Provider may share my protected health information.

SIGNATURE: _____ DATE: _____