Berkshire Health Systems, Inc.

Involvement in Care

Patient Name: _____ **Date of Birth:** _____

Location: _____

I hereby request that the following person(s) be allowed to participate in my care or payment-decision process. I understand that these person(s) may be given health or payment information about me if I am unavailable or unable to communicate. Berkshire Health Systems will act on this information until I revoke or amend this authorization in writing.

Please designate who you would want to be your Care Partner/Key Learner/Care Giver in receiving education: _____

***Note*: In the event that this person is to be involved in healthcare <u>decisions</u> for this patient, a healthcare proxy must be completed in accordance with the related policy.**

Name	Relationship	Date of Birth	Phone Number	Type of Information to be Released

Berkshire Health Systems will make a reasonable effort to provide only the necessary information for the person(s) to make an informed decision or to receive printed protected health information.

The below is for use in Outpatient Clinics and Services only:
Please circle Yes or No for each line:

Yes No I give permission to call me at home or on my cell

Yes No I give permission to leave a message on my voice mail

Yes No N/A I give permission to leave a message with: _____

Yes No I give permission to send a note/letter to my home address or P.O. Box

_____ _____ _____ _____
(Date) (Time) (Patient/Legal Guardian/Health Care Agent) (Relationship, when applicable)

_____ _____ _____
(Date) (Time) (Witness)