THE CENTER FOR REHABILITATION
*at* BERKSHIRE MEDICAL CENTER

# INVOLVEMENT IN CARE

Patient Name: Date of Birth:

Address: Phone #:

City: State: Zip Code:

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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.

**The following person(s) may be called in the event I am unable to be reached about my treatment schedule.**

| Name | Relationship | Date of Birth | Phone # | Type of Information to be released |
|---|---|---|---|---|
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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.

Do we have permission to leave a message on your answering machine or voice mail about your appointments? ☐ NO ☐ YES

Patient Signature: Date:

Witness Signature: Date: