St. Elizabeth PHYSICIANS

Patient Name _____ Date of Birth ____/____/____
(Print full name)

INVOLVEMENT IN CARE

I agree that St. Elizabeth Physicians, including any central service department of St. Elizabeth Physicians, may disclose my health information* at any time to the following individuals who are involved in my care:

Name _____ Relationship_____ Phone_____

Name _____ Relationship_____ Phone_____

Name _____ Relationship_____ Phone_____

Name _____ Relationship_____ Phone_____

I acknowledge that the individuals identified above are involved in my healthcare or its payment. Health information* includes test results, prescription refill information, appointment scheduling and cancellation, and billing information. Information regarding substance use disorder treatment, psychiatric or psychological conditions and treatment, pregnancy, contraception, sexually transmitted disease test results and treatment are **not** included. I understand that this consent can be revoked at any time by contacting St. Elizabeth Physicians. I also understand that nothing in this consent is intended to limit or alter St. Elizabeth Physicians ability to disclose health information to individuals not listed on this form in accordance with applicable law.

Signature X_____ Date_____
(Signature of patient or patient representative)

Witness _____