Wheaton Franciscan Medical Group

INVOLVEMENT IN CARE AGREEMENT

86181 11/2012 R3

Name _____

Date of Birth _____

Chart ID _____

Patient Name: _____ Date of Birth: _____

Wheaton Franciscan Medical Group is allowed to communicate regarding your Protected Health Information (PHI) with persons whom you indicate are involved in your healthcare. PHI includes information about your medical condition, diagnosis, treatment and prognosis, as well as billing and payment for services. You are not required to designate an individual involved in your care, but if you wish to designate an individual involved in your care we ask that you do so by completing this authorization form.

A person involved in your care may be a spouse, relative, domestic partner, or a friend. You may remove or add a person involved in your care at any time. Anyone you designate as involved in your care will have the ability to: make or confirm appointments; receive x-ray, lab or other test results; communicate with your physician or other health care provider regarding your health care; and/or communicate with Wheaton Franciscan Medical Group regarding billing and payment for services. Wheaton Franciscan Medical Group will make a reasonable effort to provide only the necessary information to the person(s).

A person involved in your care is not allowed to act on your behalf unless otherwise stipulated in a legally binding Advance Directive (Healthcare Power of Attorney, Living Will) or court approved guardianship. Therefore, anyone you designate as involved in your care will not be allowed to make decisions about your healthcare, authorize procedures or authorize any disclosure of your PHI unless such a legally binding document exists or other law super cedes. In order to receive copies of PHI, an authorization form signed by the patient/legal representative will be required.

I hereby request that the following person(s) be identified as participants in my care or payment process.

Name	Relationship	Phone Number

I understand that this authorization will be effective for the lifetime of the patient unless revoked. I understand that I may revoke this authorization at any time by notifying *Wheaton Franciscan Medical Group* in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by *Wheaton Franciscan Medical Group* prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization.

_____ _____

Signature of Patient/Authorized Representative Date

_____

Relationship of Authorized Representative