Berkshire Health Systems
www.berkshirehealthsystems.org

Involvement in Care

Patient Name: ________________________________ **Date of Birth:** ____________________

Address: ______________________________________ **Phone #:** ________________________

City: __________________________ **State:** ______________ **Zip Code:** __________________

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.

Note: In the event this person is to be involved in healthcare decisions 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.

Patient Signature: ____________________________________ Date: _____________________________

Witness Signature: ____________________________________