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/payment decision-making process. I understand that these person(s) may be given health or payment information about me at my discretion. Psychiatry Associates of Kansas City, PA will act on this information until I revoke or amend this authorization in writing.

Name	**Relationship**	**Date of Birth**	**Phone Number**	**Type of Information to be Released** (Billing, Scheduling, Clinical)

Psychiatry Associates of Kansas City, PA will make a reasonable effort to provide only the necessary information for the person(s) to make an inform decision or to receive printed/verbal protected health information.

Patient Signature: _____ Date: _____