ROBIN DALE MD
Family Medicine

Involvement In Care Form

Patient Name: ____________________________ Date of Birth: _______________

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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 (Protected Health Information – PHI) about me if I am unavailable or unable to communicate. Robin Dale MD, Family Medicine 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 power of attorney for healthcare decisions must be completed and on file.

Name	**Relationship**	**Date of Birth**	**Phone Number**

Robin Dale MD, Family Medicine will make a reasonable effort to provide only the necessary information for the person(s) to make an informed decision.

Patient Signature: ___________________________ Date: ___________________

Witness Signature: ___________________________

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Uninvolvement in Care Form

I hereby revoke any prior Involvement in Care Forms on file with Robin Dale MD, Family Medicine.

Patient Signature: ___________________________ Date: ____________________