The Mark H. Zangmeister Center

REQUEST FOR INVOLVEMENT IN CARE

Patient's Name:____

Date of Birth:_________________________ Social Security Number:_________________________

I, ________________________________ **[print your full name] (the "Patient")**, agree that Mid Ohio Oncology/Hematology, Inc., dba The Mark H. Zangmeister Center may disclose my protected health information as described below.

The individual(s) (friends, family members, etc.) listed below is/are involved in my health care, including my treatment and care received as a patient of The Zangmeister Center.

Name:___________________________________ Name:___________________________________

Address: _________________________________ Address: _________________________________

_________________________________ _________________________________

Telephone #:_______________________________ Telephone #:_______________________________

Relationship to Patient: ______________________ Relationship to Patient: ______________________

**** List additional individuals on the back of this form.*

I agree to the disclosure of my protected health information by The Zangmeister Center to the individual(s) identified above which is directly relevant to the above-named individual(s)' involvement with my care.

I further agree to the release of information to the individual(s) named above concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological condition and/or psychiatric/mental health treatment and/or HIV-related conditions when such disclosure is directly relevant to the above-named individual(s)' involvement with my care.

I agree that if at any time I no longer want the individual(s) named above to be involved in my care or for The Zangmeister Center to communicate with the individual(s) as described above, I will notify The Zangmeister Center in writing by sending a letter to the address of 3100 Plaza Properties Blvd., Columbus, OH 43219.

I also understand and agree that nothing in this request for involvement in care is intended in any way to limit or alter the ability of The Zangmeister Center to disclose my protected health information to individuals/entities not listed on this form in accordance with applicable law and professional judgment.

___________________________________ ___________________________________

Signature of Patient Date