Grace Health

Medical Care Authorization

Patient Name ____ Date of Birth _______________
(please print)

I hereby authorize Grace Health to give me reasonable and proper medical/dental care by today's standards. I authorize direct payment of insurance benefits to Grace Health, realizing I am responsible for any unpaid balance. I authorize the release of medical information to the Centers for Medicare & Medicaid Services and its agents and to my insurance company for billing purposes and to other health care providers for continued treatment, understanding that this may include records of treatment for drug and/or alcohol dependency or abuse; mental health treatment; or testing, care, treatment or reporting pertaining to infection with HIV or related diseases.

____ _____________________
(Signature of Patient / Parent/Legal Guardian) (Date)

Authorization for Verbal Disclosure of Medical Information

I authorize Grace Health to disclose and discuss medical information with the following person(s).

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I understand the information being disclosed may include medications, test results and treatment plan, including treatment for mental health, substance dependency or abuse and testing or treatment for HIV or AIDS. Once the information is disclosed, it is not protected under federal privacy rules, so there is a possibility it may be redisclosed by the person receiving the information.

____ _____________________
Patient/Legal Representative ❑ Parent ❑ Guardian ❑ ___________________________ (Date)