Grace Health

Medical Care Authorization and Consent for Treatment

Patient Legal Name _____ Date of Birth _____
(PRINT)

Preferred Name _____ Parent/Legal Guardian _____
(PRINT) (PRINT)

I hereby authorize Grace Health to give me reasonable and proper medical/dental care, which may include telemedicine services, 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, including psychotherapy notes; or testing, care, treatment or reporting pertaining to infection with HIV or related diseases.

Authorization for Disclosure of Medical Information:

I authorize Grace Health to disclose written and verbal medical information with the following person(s)as indicated below:

_____ ☐ Verbal ☐ Written

_____ ☐ Verbal ☐ Written

_____ ☐ Verbal ☐ Written

_____ ☐ Verbal ☐ Written

Consent for Treatment – Minor or Legal Ward:

I authorize the following adult (18 years or older) person(s) to seek medical care for my child or legal ward (listed as the patient above) when I am unable to do so and understand that by allowing them to seek care for the patient, this includes, but is not limited to obtaining prescriptions, consenting for immunizations, medicines and procedures, and that all medical information, verbal and written, may be revealed and discussed with them:

_____ ☐ Verbal ☐ Written

_____ ☐ Verbal ☐ Written

_____ ☐ Verbal ☐ Written

_____ ☐ Verbal ☐ Written

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)