

# 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

I do not wish to add any additional people for disclosure of my medical information.

## 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 do not authorize any non-legal guardian or person(s) to consent for medical treatment for the named patient.

***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)