HEALTH *FIRST* BLUEGRASS

Place Label Here

Internal Authorization Consent to Treat/Release Information form
Internal Use

This form grants a patient or the parent/legal guardian of the patient the ability to authorize someone to accompany the patient to the appointment and to provide consent to treat if the parent or legal guardian is not present at the appointment, understanding that Health*First* Bluegrass has an integrated healthcare model.

I, _____, HEREBY AUTHORIZE HEALTH*FIRST* BLUEGRASS TO PERMIT THE BELOW NAMED PERSON(S) TO SIGN FOR CONSENT TO TREAT AND TO RELEASE ANY/ALL MEDICAL INFORMATION THAT WOULD INCLUDE BUT IS NOT LIMITED TO: EVALUATIONS, MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT, LABWORK, PRESCRIPTIONS, TESTS, ETC. FOR PATIENT LISTED BELOW.

NAME: _____ PHONE: _____ RELATIONSHIP TO PT: _____

ADDRESS: _____

NAME: _____ PHONE: _____ RELATIONSHIP TO PT: _____

ADDRESS: _____

NAME: _____ PHONE: _____ RELATIONSHIP TO PT: _____

ADDRESS: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

PHOTO IDENTIFICATON TO BE PRESENTED WITH EACH VISIT.

I understand that this authorization will remain in effect for 1 year; however, I may revoke /cancel this authorization at any time by coming to Health*First* and completing a new form.

SIGNATURE OF PATIENT: _____ Date: _____

OR <if applicable>

SIGNATURE OF LEGAL GUARDIAN: _____ Date: _____

DESCRIPTION OF AUTHORITY TO ACT FOR THE PATIENT: _____

NAME OF WITNESS: _____

WITNESS SIGNATURE: _____ DATE: _____