HEALTH *FIRST* BLUEGRASS

Place Label
Here

PATIENT'S FULL NAME **DATE OF BIRTH**

Consent for Additional Adult to Accompany Patient/Review Health Information

This form grants a patient or for minors, patient's parent or legal guardian, 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. For the above listed patient, this would include but is not limited to: evaluations, mental health and substance abuse treatment, lab work, prescriptions, tests, or other:_____

PHOTO IDENTIFICATON TO BE PRESENTED WITH EACH VISIT.

I,_____, HEREBY AUTHORIZE HEALTH*FIRST* BLUEGRASS TO PERMIT THE BELOW NAMED PERSON(S) TO:
(Name of Patient, Parent, Legal Agent/Guardian)

- ☐ Accompany the above-named patient for appointments
- ☐ Be released the above-named patient's health information
- ☐ Make healthcare decisions for the above-named patient

Authorized Individuals:

NAME:_____PHONE:_____RELATIONSHIP TO PT: _____

ADDRESS: _____

NAME:_____PHONE:_____RELATIONSHIP TO PT: _____

ADDRESS: _____

NAME:_____PHONE:_____RELATIONSHIP TO PT: _____

ADDRESS: _____

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: _____

OR <if applicable>

RECEIVED IN BACKPACK ON: _____NAME OF PERSON RECEIVING IN THE CLINIC:_____