SIHF HEALTHCARE

Authorization/Consent to Treat

SIHF Healthcare is a partnership with local organizations to provide primary & behavioral healthcare services. By completing this form and consenting for services, you are granting permission for your evaluation and treatment. In addition, you are granting permission for the release of necessary information by SIHF Healthcare for the purpose of documenting compliance with state requirements and for the planning and delivery of quality healthcare (e.g. basic health history and immunization records).

By completing this form, you authorize insurance payment of medical benefits to SIHF Healthcare and the release of personal/health information necessary to process insurance claims.

This consent authorization will remain valid and on file with SIHF Healthcare until you are no longer a patient. You reserve the right to revoke this authorization at any time.

Consent for treatment:
I hereby consent for medical treatment encompassing routine diagnostic treatment and medical treatment by the medical staff or their designee as determined necessary in their judgment. I understand that I may revoke this consent at any point by notifying SIHF Healthcare.

I give permission for the following services:

- ☐ Physical Exams
- ☐ Immunizations
- ☐ Assessment, diagnosis and treatment of minor illness and injury
- ☐ Laboratory tests
- ☐ Behavioral/Mental Health Services (In Person & Virtual)

I DO NOT give permission for the above services:

- ☐

Contact Information (Guardian's Contact Info If Needed)

Name: (print) _____

Phone (____) _____

Address _____

Signature _____ **Date** ____/____/____

Patient's Name: _____ **DOB:** ____/____/____

Name of Organization _____

Medical History

Allergies: *(please list)*
Medication/Drugs _____

Food _____

Other _____

Chronic Illness/Hospitalization or Surgery *(please list)*

_____

_____

List of Medications Patient is Currently Prescribed:

_____

_____

_____

_____

Health Insurance
Medicaid Recipient ID# _____

Other Health Insurance
Plan Name_____ Policy Number_____

Primary Subscriber_____ Group # _____

Preferred Pharmacy
Name _____

Location_____