DAUGHTERS OF CHARITY
HEALTH CENTER

AUTHORIZATION FOR HEALTH SERVICES

PATIENT INFORMATION

Name: _____
First Middle Last

Date of Birth: _____ Medical Record #: _____

NOTE: If the patient is a minor, the parent / guardian must authorize services on behalf of the patient. Please supply the following information.

Name of Parent / Legal Guardian: _____ Relationship to patient: _____

TYPES OF HEALTH SERVICES AUTHORIZED

Health services and medical treatment may include, but are not limited to, the following: examinations, preventative treatment and education, immunizations, curative treatment, laboratory services, pharmacy services, local anesthetics, medical or minor office procedures, counseling services, and any referrals or consultations deemed necessary based on the professional judgment of the health services providers of Daughters of Charity Health Center.

PATIENT CONSENT

I, _____, do hereby authorize the health services providers of
(please print)
Daughters of Charity Health Center to provide health services and medical treatment to the patient named above.

_____ _____
Signature Date Signed

_____ _____
Witness Date Signed

form revised April 3, 2009