HealthLinkNow

Consent for Verbal Coordination of Care

Name of Patient: _____ Date: _____

Date of Birth: _____ Pt ID #: _____

By initialing each of the following contacts and signing this form, I hereby authorize HealthLinkNow to contact the following person(s), institutions or agency for coordination of care purposes.

Emergency Contact/Sig. Other/Parent:_____ Relationship:_____
Address: _____
Phone #:_____ Pt Initials:_____ Date: _____

Referral Source:_____ Relationship:_____
Address: _____
Phone #:_____ Pt Initials:_____ Date: _____

Primary Care Physician:_____ Relationship:_____
Address: _____
Phone #:_____ Pt Initials:_____ Date: _____

Other:_____ Relationship:_____
Address: _____
Phone #:_____ Pt Initials:_____ Date: _____

Other:_____ Relationship:_____
Address: _____
Phone #:_____ Pt Initials:_____ Date: _____

For the Recipient of this Information: Alcohol or drug abuse treatment is protected by Federal confidentiality rules (45 CFR part 2). Federal rules prohibit you from making further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by (45 CFR part 2).

Expiration: I understand that unless I revoke the authorization earlier, this authorization will automatically expire in 180 days from the date this authorization is signed.

My Rights: I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I have the right to receive a copy of this authorization. Patient ( ) did ( ) did not request a copy.

Signature:

Minors: I understand that minors over 12 years old must sign the authorization along with their parent/guardian.

_____ _____
Patient Signature- also required for minor over 12 Date/Time

_____ _____
Parent or Legally Authorized Representative Signature Date/Time