HĀMĀKUA-KOHALA HEALTH

Caring for your ʻohana, Caring for you

AUTHORIZATION AND RELEASE

I consent to Medical Services, Dental Services and Behavioral Health Services, Cultural Health Services (including voluntary family planning services) under the direction of the provider for which I or my dependent, have sought care. I understand that no treatment/procedure other than ordinary medical/dental behavioral health procedures will be done to me or my dependent without specific consent.

Patient name:____ DOB: ___________________________

I give Hamakua Health Center, Inc. (HHC, Inc.) permission to verify the financial and insurance information provided by me, to determine eligibility. I understand it is my responsibility to keep HHC, Inc. informed of any changes in my family income and insurance status.

I authorize HHC, Inc. to release any information necessary to secure payment from my insurance company. I also authorize the use of this signature on all insurance submissions. I understand I am responsible for all charges regardless of insurance coverage. All co-pays and balances are due at the time of visit.

I authorize payment be made directly to HHC, Inc. by my insurance company for all services provided to me or my dependent.

The information provided is accurate and complete to the best of my knowledge and is only to be used for my treatment, billing, and/or for qualification for services to which I or my dependent may be eligible.

Print name: ____ Relationship: __________________

____ _______________________

Signature (Patient/Responsible Party/Legal Guardian) **Date**

HĀMĀKUA-KOHALA HEALTH

Caring for your ʻohana, Caring for you

PATIENT CONSENT FORM to RELEASE INFORMATION

I give my consent and authorization to Hamakua Health Center, Inc. to release any information regarding my diagnostic/ medical treatment and financial status to the person(s) listed below.

Name: ____ Phone: ___________________________

Relationship: ____ DOB: ____________________________

Name: ____ Phone: ___________________________

Relationship: ____ DOB: ____________________________

Patient's Signature: ______________________________________ **Date:** ____________________________

May we say that it is the Hamakua-Kohala Health when we contact you?
[ ] Yes [ ] No, then what is the best way to contact you? ____

May we leave appointment reminders on your voicemail at the phone number(s) indicated on the Patient Information form?
_____ Yes _____ No, how would you like to be notified? ____

*** If you are here for a **confidential** Family Planning visit, what is the best phone number where we can reach you? ______________________________