Adult Consent Form Packet

Welcome | Adult Consent Form | Telehealth Consent Form | **Standard Authorization Form** | HIPPA and Checklist

First Name (Client/Patient)*

M.I.

Last Name*

Date of Birth*

MM/DD/YYYY

I authorize the release of information from this person or organization

First Name*

M.I.

Last Name*

Phone*

(###) ### ####

Address Line 1*

Address Line 2

City*

State*

Select One

Zip*

To this person or organization

First Name*

M.I.

Last Name*

Phone*

(###) ### ####

Address Line 1*

Address Line 2

City*

State*

Select One

Zip*

The information may be used/disclosed for the following purposes

For Example

Date of Care included

From*

MM/DD/YYYY

To*

MM/DD/YYYY

Signature of client or their personal representative*

Clear

Date of Signature*

MM/DD/YYYY

Printed name of client or personal representative*

Relationship to client*

Start Over | Previous | Next