



RELEASE OF INFORMATION. I authorize the Financial Counseling staff of the Hospital to assist me in the processing of any benefits application, including Medical Assistance, Aid to Families with Dependent Children, or Special Assistance, initiated for the Patient within six months of the date of this authorization. The Financial Counselor may have access to and copy any records or information to which I would be entitled. I authorize and direct the County Department of Social Services to provide such information to the Financial Counselor orally via telephone. I authorize and consent to referral to the County for benefits by use of any appropriate referral form. I request that if my benefits are approved or denied, a copy of the approval or denial be attached to and returned with the referral form. The doctrine of informed consent has been explained to me. I acknowledge that this consent is voluntary and that it may be revoked by me at any time except to the extent that action has already been taken in reliance on it. Unless otherwise revoked, this consent shall be valid for one (1) year from the date of authorization, or until final determination of any benefits application as described above, whichever is later.

I have read the foregoing request and authorization in its entirety and agree to be bound by all terms and conditions herein. Witness my (our) hand(s) and seal(s) below.

Patient _____	(Seal)	Responsible Party/ies _____	(Seal)
Witness _____		Relation to Patient _____	
Date _____	Time _____	_____ Husband	
Policyholder (if other than patient) _____		_____ Wife	
		_____ Parent/s	
		_____ Other (Specify) _____	

I have been provided access to CHS's Notice of Privacy Practices

Signature _____ Date: _____ Time: _____
(Patient or Authorized Representative)

Relationship to Patient: _____
 Reason Patient Unable/Unwilling to sign _____

TELEPHONE CONSENT FOR TREATMENT

Name/Title of 2 Persons Witnessing Consent:	Date	Person Called:
1. _____		
2. _____	Time	Relationship to Patient:
Consent Granted: Yes _____ No _____	Remarks: _____	

