TAK Center for Mental Health

HIPAA & Consent

Today's date: / / **Primary Care Physician:**

Patient's last name:	**First:**	**Middle Initial:**	**Marital status (circle one):** Single / Mar / Div / Sep / Wid
Former name (if applicable):	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F
Street address:		**Home phone no.:** ( )	**Cell phone no.:** ( )
P.O. box:	**City:**	**State:**	**ZIP Code:**

Race (check all that apply): ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American ❑ White ❑ Hispanic ❑ Other Race	**Ethnicity (check one):** ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Social Security No.: _____ - _____ - _____	**E-mail Address:**	**Preferred Pharmacy/Location:**

By signing below, I acknowledge the following:

- I give TCMH (TAK Center for Mental Health) consent to access my prescription history, including all past prescribed medication, in order to verify future prescription refills.
- I give TCMH consent to bill my insurance company for any fees related to services provided by their staff, perform reasonable and necessary medical examinations, testing and treatment at the discretion of its healthcare professionals based on their clinical judgment of my condition.
- I give TCMH consent to bill me directly for any charges denied by my insurance company, and for any charges incurred in the event of lack of insurance coverage at the time of care.
- I understand that TCMH is not responsible for any bills incurred by me for testing, imaging, or services provided by outside facilities, including those services ordered by their staff.
- I give TCMH consent to call, text, and/or email an appointment reminder to the phone number listed above. I understand that there may be a voicemail left for me at this phone number.
- I acknowledge that I have been given access to TCMH's Notice of Privacy Practices.
- I authorize TCMH to discuss my health information with the following person(s):

_____ _____ _____
Name Telephone # Relation

_____ _____ _____
Name Telephone # Relation

❑ Self Only: *If checked, TCMH will not release your information to anyone except as outlined in our Notice of Privacy Practices. Please initial* _____

I release TAK Center for Mental Health (TCMH) from all responsibility and liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to TCMH, provided that I do so in writing and to the extent that we have already disclosed the information in reliance on this authorization.

_____ _____
Patient Signature (or *Guardian if patient is under the age of 18*) Date

_____ _____
Witness Signature Date