Community Health Connections

We take great care of you!

Fitchburg Community Health Center/Greater Gardner Community Health Center

Leominster Community Health Center/ACTION Community Health Center

Medical Consent for Treatment

I, _____, DOB: _____ hereby authorize Community Health Connections Physicians/Nurse to administer medical treatment, and /or medical procedures as recommended by my medical providers after discussion with me. I authorize the exchange of my medical information to the Community Health Connections Behavioral Health and Dental departments as needed for coordination of my care. I understand that Behavioral Health services are integrated into Primary Medical Care and may be included in my care plan. I authorize Community Health Connections to release any necessary information including the diagnosis and records of treatment or examination rendered to me during my care to third party payors and/or health practitioners. I authorize and request my insurance company to pay Community Health Connections directly for my care.

Signature: _____ Date: _____

Witness: _____ Date: _____

(Minor Patients)

I, _____, (Parent/Legal Guardian) of _____ DOB: _____ hereby authorize Community Health Connections Physicians/Nurse to administer medical treatment, and /or medical procedures as recommended by my child's medical providers after discussion with me (or their other parent/legal guardian). I authorize the exchange of my child's medical information to the Community Health Connections Behavioral Health and Dental departments as needed for coordination of my child's care. I understand that Behavioral Health services are integrated into Primary Medical Care and may be included in my child's care plan. I authorize Community Health Connections to release any necessary information about my child, including the diagnosis and records of treatment or examination rendered to him/her during his/her care to third party payors and/or health practitioners. I authorize and request my child's insurance company to pay Community Health Connections directly for his/her care.

The following people are authorized to consent for my child's care:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Signature: _____ Date: _____

Witness: _____ Date: _____