



Healthcare Management Services

Request for Healthcare Services: Patient Authorization

Patient Name: _____ Patient DOB: _____

Patient Location: _____

Service(s) Requested: Psychiatry Psychotherapy Primary Care
South Carolina only

I request the above services from the LifeSource of NC, Inc. clinician designee(s).

I have been informed of my rights, including the right to consent to or refuse treatment; I have received or been offered a copy of LifeSource’s Notice of Privacy Practices, Client Rights’ and Grievance policies, which provide information about how LifeSource uses and discloses Protected Health Information.

I authorize any entity with medical information about me to release said information to my insurance company or to the Centers for Medicare and Medicaid Services and its agents, if needed, to determine the benefits payable for requested services.

I request that payment of authorized insurance benefits be made on my behalf to the LifeSource clinician designee for requested services. I understand that my insurance company may assign a portion of the bill as patient liability. I understand that my financially responsible party may be informed that I am receiving services for billing purposes unless I request otherwise.

I authorize the release of information to my Attending Physician and/or facility for the purpose of coordination of care. I understand that my medical records will be kept on file at the site where requested services are provided, and that the release/ disclosure of my protected health information is subject to all HIPAA guidelines. The duration of this consent is until the discontinuation of service by the provider or patient.

REQUIRED SIGNATURES: *(If POA signs on patient behalf, proof of invoked POA status is required)*

Patient or Legal Guardian Signature Patient or Legal Guardian Printed Name Date

Witness Signature *(If signature illegible)* Witness Printed Name Date

Or, in accordance with Medical Statutes:

Responsible Party Signature Responsible Party Printed Name Date

Relationship to Patient (required): _____