

## Authorization & Informed Consent

If you are not the legal guardian, a signed consent form is required from the custodial parent. If you are divorced, a copy of the divorce papers stating your legal guardianship is required prior to treatment.

I agree and consent to participate in the behavioral health care services offered and provided by Agape Youth Behavioral Health. I understand that I am consenting and agreeing only to those services that my provider qualified to provide within the scope of the provider's license, certification, and training.

I authorize Agape Youth Behavioral Health to release to my insurance company, managed care organization, state agency (ies), Health Care Financing Administration, third party administrators, and/or Worker's Compensation or its agents any information needed to process my claim and/or determine benefits payable to related services. I also authorize Agape Youth Behavioral Health to utilize a fax machine to transmit and/or all of the above medical records pertaining to my medical care of insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of medical records.

I grant permission for Agape Youth Behavioral Health to release all or part of my medical records to any consulting entity that may be involved in my medical care. This includes, but is not limited to the purposes of treatment, payment, and healthcare operations.

I request that payment of Medicare, Medigap, Traveler's Railroad Retirement, Managed Care Organizations, Third Party Administrators, Commercial, Worker's Compensation, Liability, and/or any other insurance benefits be made on my behalf to Agape Youth Behavioral Health for services furnished to me or on my behalf by that provider.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Notice of Privacy Practices

I have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\* A copy is available for your records at your request.

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