PREAUTHORIZATION FOR MINORS AND UNEMANCIPATED ADULTS

For families who have established relationships with our practice, it may be convenient to have on file prior authorization for medical care for children or adults when a parent or guardian cannot be present for treatment. Please complete the following form if you want to authorize the treatment in advance.

I request and authorize Bracken Psychiatric Services and its personnel to deliver medical care to my child/dependent listed below:

Name _____ D.O.B. _____

I certify that any individual authorized is at least 18 years of age, speaks and understands fluent English (excluding individuals under the Americans with Disabilities Act) and has a general knowledge of the patient's current medical history.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

I understand that incomplete forms will be null and void; no exceptions.

I understand that specific information to be disclosed may include history of Drug or Alcohol Abuse or Mental Health Treatment, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Immune Deficiency Syndrome (AIDS), laboratory test results, treatment progress, and any other such related information.

This authorization will expire 1 year from the date of my signature.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to:
Privacy Officer: 3200 Southern Dr. #107 Garland, TX 75043
Phone: 972-278-5385 Fax: 972-692-8687

_____ _____ _____

Printed Name of Patient Guardian or Legal Representative

Signature of Patient Guardian or Legal Representative

Date

_____

Relationship to Patient