Acct #: _____

AMS

Alton MultiSpecialists

One Professional Drive
Alton, IL 62002
(618) 463-8500

Patient Name: _____ DOB: _____
(Please Print)

INFORMATION RELEASE

I give permission for Alton MultiSpecialists' physicians & staff to involve the below named person(s) in my or my minor child medical care. This includes discussing my medical condition, diagnosis, plan of care, treatment, release of prescriptions, and/or medication samples, etc.
Please identify by name and relationship: _____
_____ **Additional names on back** ☐

This is in effect for:

____ for all my medical care **including** HIV/AIDS related information, mental health records, and alcohol/substance abuse information

____ For only the following medical condition(s) or dates treated (please list)_____

AMS routinely sends a copy of your medical record to your primary care physician. If you do not want a copy sent, please check the box provided: ☐

Doctor:_____

Emergency Contact:
Name:_____ Phone #:_____

_____ _____
Patient (Guardian) Signature Date

CONSENT FOR TREATMENT & DISCLOSURE AUTHORIZATION

I hereby authorize Alton MultiSpecialists physicians and staff to provide medical treatment and services to me and/or my minor child. I understand that my protected health information may be used and disclosed to carry out treatment, payment, or healthcare operations. I further understand that the above stated information is in the AMS NOTICE OF PRIVACY POLICIES, which I have received a copy of today. AMS reserves the right to refuse treatment in non-emergent situations if I refuse to sign this form. I fully understand and accept/decline the terms of this consent.

_____ _____
Patient's (Guardian) Signature Date

This section to be filled out in exam room

AUTHORIZATION BY A MINOR PATIENT

I am under age 18. In accordance with Illinois Law and Federal Regulations, I do not require parental authorization if treatment is related to any of the following: **birth control services, HIV/AIDS, sexually transmitted disease (ages 12-18), chemical dependency (alcohol or drug)(12-18), or psychiatric treatment**. I give permission for Alton MultiSpecialists' physicians & staff to involve the below named person(s) in my medical care of the above named conditions. This includes discussing my medical condition, diagnosis, plan of care, treatment, release of prescriptions, and/or medication samples, billing information, etc.
Name: _____ Name: _____

_____ _____
Patient's Signature Date

Continue of List Name(s) & Relationships

Patient's Signature

Date

Patient's Signature

Date

Patient's Signature

Date

Patient's Signature

Date