HealthFirst
Family Care Center, Inc.

AUTHORIZED REPRESENTATIVE FORM

You may choose an authorized representative to help you obtain and continue to receive health services at HealthFirst Family Care Center, Inc. This representative may attend appointments with you, fill-out applications, pick-up medications, and discuss your care with your provider, nurse or other staff member.

Please initial each item you would like an authorized representative to assist you with:

_____ Picking-up my medications, samples or prescriptions. (Please note that HealthFirst will not replace any prescriptions or medications that an authorized representative has lost or misplaced.)

_____ Going-over my test results, health concerns and instructions for care.

_____ Applying for financial programs that may help cover medical costs.

_____ Discussing my health with my provider or nurse.

_____ Discussing my concerns with a social worker.

_____ Discussing my concerns with a behavioral health specialist.

This authorization does not expire. Please be sure to tell us if you wish to change anything related to your authorized representative including telephone numbers.

Please read and check each statement below:

☐ I have read and understand how an authorized representative might help me receive care from HealthFirst Family Care Center, Inc.

☐ I understand that I am responsible for my authorized representative providing accurate information to my healthcare provider(s).

☐ I wish to select an authorized representative, and I am making this decision on my own.

Patient Authorization and Consent:

_____ _____

Patient Name (please print) Patient Signature

Authorized Representative Consent:

I understand my responsibilities as an authorized representative, and I agree to accept them as outlined above.

_____ _____

Authorized Representative Name (please print) Authorized Representative Signature

_____

Authorized Representative Telephone Number

Form Updated: 10/11/2016