# HEALTH CARE PARTNERS OF SC, INC.

123 E. Broadway St.
Johnsonville, SC 29555
843-386-3573
Fax: 877-322-0181

243 Singleton Ridge Rd.
Conway, SC 29526
843-248-4700
Fax: 877-322-0181

1608 N. Main St.
Conway, SC 29526
843-248-4700
Fax: 877-322-0181

145 Palmetto Pointe Rd.
Marion, SC 29571
843-423-2400
Fax: 877-322-0181

## PATIENT TREATMENT AUTHORIZATION FORM

Printed Patient Name: _____ Patient DOB: _____

I _____ hereby authorize the administration of medical/dental treatment(s) and the performance of medical/dental procedure(s) while _____ (Patient's Name) _____ is a patient at Health Care Partners of SC, Inc.

I understand that such treatment(s) and procedure(s) will be performed by physicians, certified nurse-midwives, nurse practitioners, dentist and/or dental hygienists and/or nurses and employees of Health Care Partners of SC, Inc. The intention hereof is to grant full authority to such physicians, certified nurse-midwives, nurse practitioners, and their respective assistants to administer and preform all drugs, treatments, test, or diagnostic procedures including the testing for infectious diseases such as, but not limited to Syphilis, Hepatitis B, and AIDS/HIV. I further consent to the testing for drugs if deemed advisable by or necessary in the professional judgement of physician, certified nurse-midwives, nurse practitioners, or dentist. Physicians, certified nurse-midwives, nurse practitioners and case managers for Health Care Partners of SC, Inc. have my permission to reveal information to appropriate agencies and individuals where it becomes necessary to protect the welfare of myself, the patient, and/or the community. I consent to and authorize the above mentioned for or upon me, or the person for whom I am authorized to consent.

Health Care Partners of SC, Inc. is authorized to furnish information or excerpts to another physician or provider, if any, and to any insurance company or authorized third party payer for the purpose of obtaining payment of the account of Health Care Partners of SC, Inc. for the services provided to the patient. I expressly agree to be personally responsible for any portion of the amount that is not paid by a third-party payer.

In addition to the above sources, I hereby give Health Care Partners of SC, Inc. permission to disclose or receive information to or from the following individuals.

| NAME | RELATIONSHIP TO PATIENT |
|---|---|
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I hereby certify that I have read and understand the above authorization and that inappropriate paragraphs/sections, if any, were stricken and initialed by me before I affixed my signature and that no guarantees or assurances have been made as to the results of treatments and procedures(s)

_____ Date: _____

Signature of Patient or Patient's Representative/Parent/Legal Guardian

_____ _____

Printed Patient Name Relationship to Patient

_____ Date: _____

Witnessed by