Miller Care Group

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Indianapolis, IN 46254
Telephone: 317-429-0061
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CONSENT/AUTHORIZATION FOR PROCEDURE/TREATMENT FORM

I authorize Miller Care Group to perform the treatment/procedures described below. I have been informed of the reason for the treatment/procedures along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved in the following.

____ Mental Behavioral Counselling

____ Addiction/Substance Use Disorder

____ Psychiatric Care

____ Primary Care

____ Advance Wound Care & Lymphedema.

____ Spravato

____ Palliative Medical Care

____ Telehealth Visits

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_____
Printed Full Name

_____ _____
Patient Signature/E-Signature Date

Miller Care Group Notice to Recipient: This authorization provides for a ·release of information about an individual whose confidentiality is protected by federal and state laws and regulation, including the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. §160-164) as well as 42 C.F.R part 2 and 42 U.S.C. §. §290dd-2, and state confidentiality laws. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.