VALLEY HEALTH TEAM
LIVE BETTER. VIVE MEJOR.

SERVICES AUTHORIZATION FORM

CONSENT TO TREAT

The information I have provided on the registration form is true and correct to the best of my knowledge. Based on this, I wish to register as a Valley Health Team, Inc. patient. I give my consent to all services ordered by the attending physician when appropriately informed of the reason and consequences of said services.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Valley Health Team, Inc. to release any information acquired in the course of my examination or treatment.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

AUTHORIZATION TO PAY BENEFITS

I hereby authorized payment of benefits to which I am entitled, directly to Valley Health Team, Inc.

_____ _____
Signature of Patient, Parent or Legal Guardian Date