Camp Lakota 2017

Treatment Authorization Form

Please return this form by
June 1st to upload to Camp Brain Account
Or fax to 845-402-7440

I/we, the undersigned, parent/guardian of... (please list your campers below)
1._____
2. _____
3. _____
4. _____
a minor(s), do hereby authorize Kota Kamp Inc. dba Camp Lakota, Michael Childs, Lenny Durante as Directors or any other Head Staff as our agent(s) to consent to any diagnostic procedure or medical care which is deemed advisable by and is rendered under the general supervisor of any licensed physician at Community General Hospital of Sullivan County, Orange Regional Medical Center, Catskill Regional Hospital, Crystal Run Urgent Care of Rock Hill, NY or any equally accredited medical facility, when such diagnosis or treatment is rendered at such institution. It is understood that the authorization is given in advance of any specific need for treatment, but is given to provide authority on the part of the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician, in the exercise of his best judgment, may deem advisable.
I authorize the use or disclosure of the above-named individual's health information. All individuals and organization are authorized to make the disclosure. The type and amount of information to be used or disclosed is not limited to, but includes: problem lists, medication lists, immunization records, allergy lists, history and physical reports, discharge summaries, laboratory results, radiology notes, reports and films, consultation reports, and entire medical records. This authorization shall remain in effect until August 15, 2015 unless sooner revoked in writing and delivered to such agent(s).

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR(S) TEMPORARILY SEPARATED FROM PARENTS AND HIPPA (Health Insurance Portability and Accountability Act) CONSENT AND WAIVER

_____ _____ _____
Parent Signature Print name Date

_____ _____
Street Address City State Zip

_____ _____ _____
Insurance Policy Holders Name Policy Holder Employer Employer's Phone#

_____ _____ _____
Employer's Email address Medical Insurance Company Policy No.
Is a referral required? Yes No _____ _____
(please circle one) Prescription Insurance Company Policy No.

_____ _____
Dental Insurance Company Policy No.
A PHOTOCOPY OF EACH CARD MUST BE ATTACHED.