☐ **Enrollment**

☐ **Reenrollment**

New Horizon Family Health Services Ryan White Program

Consent for Services and Release of Information

Patient Name:______________________________________ Athena #:____________________

Address: ____

City/State:_ ______________________________________Phone: _______________________

I hereby consent to become a patient of the New Horizon Family Health Services Ryan White Program. By my signature below, I authorize the following agencies to release information to and /or receive pertinent information from New Horizon Family Health Services.

Please Initial

_____ AID Upstate

_____ Upper Savannah Care Consortium

_____ County Health Department

_____ Greenville County Detention Center/LEC

_____ Hospital- ____

Signature:____Date:_______________________

Witness:____Date:_______________________

Revised 05/19/2016