Consent for Treatment/ Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Name of Patient: _____Date of Birth: _____ Today's Date**:** _____

CONSENT TO TREATMENT:

- I consent to care at CentroMed for routine diagnostic procedures, examination, medical, dental, optometry and behavioral health treatment. This includes, but is not limited to, routine laboratory work such as blood, urine, and other studies, including testing for the human immunodeficiency virus (HIV), and acquired immune deficiency syndrome (AIDS), unless I decline by telling my medical provider, any and all immunizations (except in case of an exemption), taking of x-ray, photo's, heart tracing, administration of medications prescribed by the physicians, dentists, mid-level providers, and nurse practitioners.
- I consent to electronic retrieval of my medication history via sure scripts or other electronic scripts.
- I further consent to the performance of those procedures, examinations, treatment, and intervention by medical, dental, optometrist, including physician's assistants, social workers, and counselors as is necessary on the professional staff's judgment.

PATHOGEN EXPOSURE POLICY:

In the event of any healthcare provider's exposure to my blood and/or body fluids:

- _____I consent or _____I do not consent at this time to laboratory testing for HIV, Hepatitis B, and Hepatitis C and to the release of results to the person exposed consistent with confidentiality protections.

ACKNOWLEGDEMENT OF RECEIPT OF NOTICE:

Initials

_____

- **I have received a brochure about my rights and responsibility as a patient**, including CentroMed's policies on confidentiality, Advance Directives, and filing a complaint. I further understand and have been provided with a ***Notice of Client Privacy Rights.***

- I understand the following:
  - I have the right to review the notice prior to signing this consent
  - I understand I may use CentroMed separate form to authorize someone to consent to treatment of my minor child.

PERMISSION TO COMMUNICATE (OPTIONAL):

Initials

- _____ I permit CentroMed, its physicians, nurses, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: Please list family members/friends, telephone number, and state the person's relationship to the patient.

Name	**Phone Number**	**Relationship**
_____	_____	_____
_____	_____	_____

CDB Form No. 2004 (Rev 11/2016)

This permission is limited to discussions regarding the following medical condition(s):

_____ .

(If no limitations are listed, discussions will be permitted regarding **any** medical condition for which the patient has received care.) Release of information under this permission to communicate is limited to verbal discussions with my healthcare providers. This document does not permit release of any written health information to the individuals named above. **(Authorization for the Use and Release of Protected Health Information form should be used for release of written health information.**)

- This permission to communicate is limited to the following timeframe from:
    - _____ (date) to _____ (date). If no dates are indicated, this permission will remain in effect for an unlimited amount of time. **If, at any time, I do not want verbal discussions to be permitted between my healthcare providers and any of the individuals named above, I must notify my healthcare Provider by contacting CentroMed in writing.**

CONSENT FOR USE/DISCLOSURE OF INFORMATION FOR TREATMENT/PAYMENT/HEALTHCARE OPERATIONS:

- I understand that as part of my health care, CentroMed originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:
    - A basis for planning my care and treatment
    - A means of communication among the many health professionals who contribute to my care
    - A source of information for applying my diagnosis and surgical information to my bill
    - A means by which a third-party payer can verify that services billed were actually provided
    - A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals
- I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to use and disclose my protected health information including disclosure to another entity, and I consent to such use and disclosure, for these permitted uses, including disclosure via fax.
- Disclosure of protected health information under this paragraph may include disclosure of HIV/AIDs testing only to the extent permitted by law without a separate written authorization by patient.
- I authorize CentroMed to enter and view my BCCS/Komen clinical services/data history in the Med-IT database**.**
- I also give consent to CentroMed to confirm my appointments with a continuum of care agency as necessary.
- I understand that this consent form will be valid and remain in effect as long as I attend the clinic. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me to the extent permitted by law.

ELECTRONIC ACCESS BY PATIENT:

_____I give consent to CentroMed staff to provide me with electronic access to health information and, upon my request, to an electronic copy of my health information through private and secure access email.

This form has been fully explained to me and I understand its contents. I fully understand and accept the terms of the consent.

_____ _____
Signature of Patient, Parent or Legal Guardian/Authorized Person Date

_____ _____
Print name of Patient, Parent or Legal Guardian/Authorized Person Relationship to Patient

_____ _____
Signature of Staff Date

CDB Form No. 2004 (Rev 11/2016)