Community Health Care, Inc.

MRN#_____

CONSENT FOR TREATMENT ADULT

I, _____allow the providers and employees of Community Health Care, Inc. (CHC) to assess and treat my health needs. This includes anything needed to diagnose me; any photographs that are needed to treat my medical needs, any shots, or any treatments ordered by CHC providers.

I give my permission to release my health/financial information that is needed to conduct audits and/ or process insurance claims including: HIV, mental health, STDs, genetic testing, and drug abuse. I also give permission for the payment of the claim for services be paid to CHC on behalf of the provider. I also ask for government benefits to be paid to CHC on behalf of the provider who accepts them.

COMMUNICATION WITH FAMILY & OTHERS INVOLVED IN YOUR CARE

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, please indicate what type of information may be shared with each person. **(Choose below)**

I will allow the following names listed below to consent for selected items only.
It does not allow release of records, which will require a separate signed release of information.

NAME	Relationship	ALL	Scheduling/ Appointment	Office Visits	Billing	Prescriptions	HIV
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐

Specific Instructions or Limitations: _____

I give my consent to leave detailed information on voice messages and/or send detailed text messages. This may include lab results, test results, form/records information, and medication information. This **WILL NOT** include mental health, substance use, sexually transmitted diseases, genetic testing, and HIV information. We will need to speak to you directly about this type of information.
It is your responsibility to ensure we have your most current phone number on record.

Please mark your choice to participate in receiving detailed voice messages and text messages.	
☐ Yes, I consent	☐ No, I do not consent

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. I know that I need to update the consent form and notify CHC immediately if changes need to be made for demographic, insurance coverage, etc. This consent is valid until I tell CHC to cancel it.

_____
Signature Date

_____
Printed Name Date of Birth