COMMUNITY HEALTH CARE, INC. CONSENT FOR TREATMENT ADULT

Patient_____Birthdate_____Chart #_____

I,_____, allow the providers and employees of Community Health Care, Inc. 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 Community Health Care, Inc. providers.

- I have been given a copy of the Patient Bill of Rights and Responsibilities and have been able to ask questions about it. _____(initials)

- I have been given a copy of the Notice of Privacy Practices. I can get extra copies of the notice when I ask for one. _____(initials)

- After your visit we give you a written health plan. We are not legally liable for the privacy of your information if you leave it or lose it. _____(initials)

I give Community Health Care my consent to leave detailed information on voice 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.

- ☐ Yes
- ☐ No

- **I know that I need to update the consent form if changes need to be made. This consent is valid until I tell CHC to cancel it. _____(initials)**

_____(initials)

- **Authorization to release information from CHC for work activities:** This information can be released to patient's work/school for the purposes of participation of work activities or functions to include but not limited work physicals, excuse for attendance at an appointment, or Family Medical Leave Act (FMLA) documentation.
- The information is to be limited to physicals, laboratory test results related to work and vaccination information.
- I understand that no information for mental health, substance use, sexually transmitted infections, genetic testing, or HIV will be provided. Those items require a separate release of information.
- This information will be provided by mail, fax or to you for hand carrying. Please note once provided to you or your work, CHC is no longer responsible if it is accessed at your work, or you leave or lose it.

(Continues on back)

Patient_____Birthdate_____Chart #_____

- I further understand that this release is valid for one (1) year from the date of signature below.
- I may restrict or cancel this authorization at any time.
- If I do not sign below or cancel this release, CHC will not send the information but does not stop you from being seen for care at CHC.
- No medical records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirement (42 CFR Part 2) prohibit further disclosure without the specific written consent of the patient.

- **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 individual. **(Choose below)**

☐ **I will allow the following names listed below to consent for selected items only. <u>It does not allow release of records, which will require a separate signed release of information form for non-school records.</u>**

	TYPE OF INFORMATION						
NAME: RELATIONSHIP TO PATIENT:	All	Scheduling/ Appointment	Medical	Billing/ Insurance	Dental	HIV Info	Prescriptions
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐

Specific Instructions or Limitations: _____

_____

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. For us to change your information please come in and fill out a new form. _____(initials)

I give Community Health Care my consent to send a reminder for me to come to my appointment by text message with the location, date, and time of my appointment. CHC will keep sending reminders this way until I ask them to stop. Message and data rates may apply. _____(initials)

Yes, Cell Phone Number:_____

_____ _____

(Signature of Patient/Legal Representative) (Patient's Name Printed)

_____

(Date)