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

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

I hereby consent to care at Unity Health on Main 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 immunization, taking of x-ray, photo's, heart tracing , administration of medications prescribed by the physicians, dentists, mid-level providers, and nurse practitioners, and electronic retrieval of my medication history via sure scripts. I also give consent to Unity Health on Main 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, and to confirm my appointments with a continuum of care agency as necessary. 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.

I also understand that as part of my health care, Unity Health on Main 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 provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

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Initials

I have received a brochure about my rights and responsibility as a patient, including Unity Health on Main's policies on confidentiality, Advance Directives, and filing a complaint. I further understand and have been provided with a ***Notice of Client Privacy Rights*** that provides a more complete description of information uses and disclosures.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations
- The right to delegate consent to treat a minor

I understand that Unity Health on Main is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Unity Health on Main reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Unity Health on Main change their notice they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information: _____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such 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 understand that this consent form will be valid and remain in effect as long as I attend the clinic. 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/Legal Representative Date

If patient is 17 years or younger, or is unable to consent, complete the following:

A. Patient is a minor- years of age _____ *Name of Father* _____ *Name of Mother* _____

B. Patient is unable to consent because _____

C. Name of person giving consent, if different from patient: _____ *Relationship to patient:* _____

_____ _____
Signature of Parent or Guardian Date

_____ _____
Staff Signature Date