consensushealth™

CONSENT, DISCLOSURE AND AUTHORIZATION FORM

Patient Name: _____ Medical Record #: _____

Address: _____ DOB: _____

As used in this form, the words "I," "me," "my" and similar references mean the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

General Consent for Examination and Treatment

I hereby consent and authorize Consensus Health and all physicians and ancillary medical personnel of Consensus Health, to perform medical examinations and provide routine medical care for all my visits to Consensus Health. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of Consensus Health. Any photographs or other images taken will become part of my medical record. Consensus Health will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that Consensus Health will provide me with information and forms prior to such procedures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and understand Consensus Health's HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that Consensus Health has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, Consensus Health will post a new notice in the office. I may contact Consensus Health at any time to obtain a current copy of the HIPAA Notice of Privacy Practices. I may also access a copy on its website.

Consent To Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize Consensus Health to use and disclose my health information, which includes all or any part of my medical records, including drug or alcohol treatment information, genetic, genetic counseling and genetic testing information, HIV/AIDS information, and any other information concerning my diagnosis or treatment, as well as demographic information, by and to its workforce members and to health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of Consensus Health. I understand that, for example, my health information may be used or disclosed by Consensus Health to: provide for my care and treatment; communicate among various health care professionals who are involved in my care or treatment; bill for and obtain payment for care and treatment provided by Consensus Health; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations. In addition, I understand Consensus Health may release my protected health information as required by law or court order.

Patient Name: _____ DOB: _____

Disclosures to Authorized Individuals

I understand that Consensus Health may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care (circle as applicable), to whom the information circled "yes" below may be released:

Name: _____ Relationship: _____

Address: _____

Phone: _____ Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Name: _____ Relationship: _____

Address: _____

Phone: _____ Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Name: _____ Relationship: _____

Address: _____

Phone: _____ Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Name: _____ Relationship: _____

Address: _____

Phone: _____ Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Contact Information

I understand that if I have checked the box "detailed message," I agree that Consensus Health may leave any of the following detailed messages at the indicated telephone number: appointment reminders, insurance/financial issues, biopsy or other test results, and any other information regarding care/treatment.

I wish to be contacted in the following manner (Please check all that apply):

☐ Home Telephone: (_____) _____ ☐ Detailed Message ☐ Call Back Message Only

☐ Work Telephone: (_____) _____ ☐ Detailed Message ☐ Call Back Message Only

☐ Cell Telephone: (_____) _____ ☐ Detailed Message ☐ Call Back Message Only

☐ Mail to Home Address: _____

☐ Mail to Work Address: _____

Consent and Authorization

A copy of this consent and authorization may be used in place of the original. I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:

Patient Name: _____ Date: _____

Patient Signature: _____

Authorized Individual (Parent/Guardian) Name: _____

Authorized Individual Signature: _____

Basis of Authority (e.g., parent, guardian): _____