Medical Consent for Treatment & Disclosure of Protected Health Information (PHI)

As a patient, you have the right to be informed about your condition and the recommended course of treatment. Additionally, you may decide whether to undergo the suggested treatment or procedure after the benefits and risks associated have been explained and you have had the opportunity to ask questions of your treatment provider. This consent form is used to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for your condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating (1) this consent will remain in effect even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any satellite office under common ownership. The consent will remain in effect until it is revoked in writing. You have the right to discontinue services at any time.

By enrolling in your health benefit plan, you consent, grant, and authorize your health plan administrator to make your medical and prescription records available to CareATC, Inc. Your consent allows CareATC to contact you concerning your individual health needs and encourage participation in health and disease management programs. Your personal data will remain private and confidential and used for outreach regarding identification of emerging health risks, opportunities for additional care, gaps in care, medication adherence, and promotion of wellness, physical, and behavioral health therapies.

You have the right to discuss your plan of care with your provider about the purpose, potential risks and benefits of any treatments ordered for you. If you have concerns regarding any treatment recommended, we encourage you to ask your health care provider.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary examinations, testing, and treatment for my medical condition. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I hereby authorize CareATC® provider(s) to disclose my medical information to the below designated individuals. I waive all rights and privileges allowed by law relating to disclosure of confidential information and release the facility, its agents, and employees from legal responsibility arising from the release of the information to the below designated individuals.

The following listed individuals may be informed of my medical conditions: Name and Relationship

_____ _____

_____ _____

_____ _____

Print Name of Patient or Personal Representative _____

Relationship to Patient _____

_____

Signature of Patient or Representative Date

_____

Print Name of CareATC Witness Witness Signature Date

The information that you authorize for release may include sensitive medical information relating to sexually transmitted infections, mental health and substance use treatment.