partnership HEALTH CENTER
PHCTR Integrity Health

Consent for Treatment

I, _____ am authorized and hereby give consent for the medical staff
(Patient/Guardian)
of the Partnership Health Center to examine and render care to _____.
(Name of Patient/Self)

This consent shall remain in effect until revoked in writing.

Your privacy is of utmost concern to us at Partnership Health Center and we strictly adhere to HIPAA regulations. These regulations do allow us to call you at a phone number provided by you for specific purposes. We can call you to remind you of upcoming appointments and to leave either a voice mail message or a message with the person who answers the phone asking you to call us back. We do not leave Personal Health Information (PHI) unless authorized by you.

Please read the following statements and indicate you acknowledgement and/or authorization for each:

____ I acknowledge that I have received/read a copy of the Center's HIPAA information.

____ I authorize the staff of the Partnership Health Center to leave detailed messages only via voice mail on the phone number provided. These messages may contain Personal Health Information (PHI) such as the results of tests.

____ I authorize the staff of the Partnership Health Center to leave detailed messages containing PHI t any person answering the below phone number(s).

Authorized Phone Number(s): _____ or _____.

Please indicate the people you authorize to either pick up prescriptions and/or refills or other medical supplies for you AND the people you authorize with whom the staff (including our providers) may discuss your medical condition(s). This will include PHI. Please circle Yes or No for each person.

Authorized Person(s)	Relationship	Rx Pick Up	Discuss PHI
_____	_____	Yes No	Yes No
_____	_____	Yes No	Yes No
_____	_____	Yes No	Yes No
_____	_____	Yes No	Yes No

Signature: _____ Date: _____

Witness: _____ Date: _____