All-Inclusive Community Health Center
1311 N. San Fernando Blvd., Burbank, CA 91504
3920 Eagle Rock Blvd., Ste. A Los Angeles, CA 90065
17114 Devonshire St., Ste. 200 Northridge, CA 91325
17114 Devonshire St., Ste. 101 Northridge, CA 91325
Tel: 818-843-9900 Fax: 818-843-9901 E-mail:info@aichc.org

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by **ALL-INCLUSIVE COMMUNITY HEALTH CENTER (AICHC)** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **AICHC**. I hereby authorize All-Inclusive Community Health Center (AICHC) to charge my credit/debit card for any amounts for which I am financially responsible related to services rendered.

I understand that diagnosis or treatment of me by **AICHC** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **AICHC** is not required to agree to the restrictions that I may request. However, if **AICHC** agrees to a restriction that I request, the restriction is binding on **AICHC.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **AICHC** has taken action in reliance on this consent.

My "**protected health information**" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that disclosure of my "protected health" information may be mandatory under certain circumstances that are outside the "Limits of Confidentiality". These include, but are not limited to, disclosure if I may harm myself or others, disclosure in the case of child abuse, elderly abuse or domestic violence, disclosure to public health authorities regarding certain reportable diseases, and other circumstances as they relate to legal and/or oversight requirements by regulatory agencies.

I understand I have a right to review **AICHC's Notice of Privacy Practices** prior to signing this document.
AICHC's Notice of Privacy Practices has been provided to me.
The **Notice of Privacy Practices** describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **AICHC**.
The **Notice of Privacy Practices** for **AICHC** is also provided **on the notice or bulletin board.**
This **Notice of Privacy Practices** also describes my rights and the duties of **AICHC** with respect to my protected health information.

AICHC reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices.**

I may obtain a revised **Notice of Privacy Practices** by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Consent for Minors and Compliance with State/Federal Laws
Before any minor receives medical, dental, behavioral health, preventive, or counseling services at All-Inclusive Community Health Center, consent from a parent or legal guardian is required in accordance with applicable state and federal laws. This includes services related to sensitive topics such as sexual identity or reproductive health, except where state law permits minors to consent on their own.

By signing below, I affirm that:

- If I am the patient and an adult, I consent to treatment as described in this form.
- If the patient is a minor, I am the parent or legal guardian authorized to provide consent for all services as required by law.

Signature of Patient or Personal Representative	Date of Birth	Name of Patient or Personal Representative
_____	____/____/____	_____

Description of Personal Representative's Authority	Date
_____	_____/_____/_____