



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 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