## AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/PRIVACY NOTICE

| PATIENT: | DOB: | DATE: |
|---|---|---|
| | | |

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize CHDC (Community Health and Dental Care, Inc.), its health practices and providers including physicians, dentists, integrated behavioral health providers, medication assisted treatment team, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending health practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures.

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for Community Health and Dental Care, Inc.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized health benefits is made on my behalf directly to the CHDC provider of service(s) furnished to me. I authorize CHDC to release any health information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to CHDC. I hereby authorize that photocopies of this form to be valid as the original.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through CHDC health practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a CHDC billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with CHDC's approval, I understand that appropriate collection measures may be initiated.

ELECTRONIC HEALTH RECORD: Healthcare providers require access to patient health information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. CHDC has a system-wide electronic health record that is available to caregivers on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated CHDC and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. CHDC and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

PATIENT PORTAL: Access to the secure patient portal is an optional service which I may suspend or terminate it at any time for any reason. I understand that my access to the patient portal will not affect the level of care that I receive. I understand that it is my responsibility to notify CHDC if there is a change in my email account or if I feel that my secure password has been breached.

ELECTRONIC PRESCRIBING: I understand that CHDC health practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my CHDC providers and my pharmacy. I have been informed and understand that CHDC providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my CHDC providers to see this health information.

IMMUNIZATION REGISTRY: I understand that CHDC participates in the Pennsylvania Department of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The
registry complies with federal health information privacy laws.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all CHDC health practices and offices provide no facilities for safekeeping of valuables. I do hereby release CHDC from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to a CHDC health practice, office or facility.

PERMISSION TO FAX CHILDHOOD IMMUNIZATION RECORD TO SCHOOLS: I do hereby grant permission for CHDC to send or fax childhood immunization records to schools, upon request.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

HEALTH INFORMATION EXCHANGES: CHDC may make your health information available electronically through a state, regional, or national Health Information Exchange (HIE) service or through *NextGen Share* ® Network to facilitate the secure exchange of your health information between and among several health care providers or other health care entities for your treatment, payment, or other healthcare operations purposes. This means we may share information we obtain or create about you with a HIE, which will be made available to outside entities (such as hospitals, doctors offices, pharmacies, or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history, or insurance information) so each entity can provide better treatment and coordination of your healthcare services. In cases where your specific consent or authorization is required to disclose certain health information to others, we will not disclose that health information without first obtaining your consent. Information that requires additional consent in order to be shared includes psychotherapy notes, treatment for substance or alcohol abuse, and records of tests or treatment for sexually transmitted diseases.

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Signature o Patient or Parent or Legal Guardian/Authorized Representative

_____ _____

Printed Name Date

_____

CHDC Representative

# CHDC Health Information Communication Preferences

PATIENT: _____ DOB: _____ DATE:_____

As our patient, we may need to reach you when you are not in the practice. For your privacy, please indicate your preferred method for us to communicate confidential health information, such as test or lab results, to you and/or others involved in your care. Please note that "appointment reminder telephone calls" may be left at the contact number(s) you list below. Please list your email address to receive online health care educational programs ordered by your care provider.

PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:

☐ Give permission to leave health information pertaining to me, my dependent or child, at the numbers listed below:

| Method | Yes | No | Area Code, Phone #, Ext., Email |
|---|---|---|---|
| Home Telephone | | | |
| Answering Machine | | | |
| Work Phone | | | |
| Cell Phone | | | |
| Email for our Patient Portal Secure Email Registration | | | |
| Email to Receive Provider-Ordered Online Patient Education Programs | | | |

**Without specific permission**, we will **not** release any health information to anyone other than you. In some cases you may wish for another person to have access to your health information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.):

☐ Do not release health information to anyone other than myself.

☐ I give permission to release health information pertaining to me to the individuals listed below.

| Name | Relationship (i.e. spouse, parent, son, daughter, etc.) | Area Code, Phone # - Extension |
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Comments

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific health information authorization at any time.

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Signature of Patient or Patient's Legal Representative Date

_____ (Please Print Name) **CHDC Representative**_____