PCHC Authorization & Notification

Patient Name: **Date of Birth:**

Penobscot Community Health Care ("PCHC") is a community health center that provides integrated medical care for physical and mental health, including dental services, to patients regardless of age, sex, sexual orientation, gender identity, color, race, ethnicity, creed, national origin, religion, physical or mental disability, or veteran status. PCHC uses an electronic health record that includes all of your medical information in one place. In order to give you the best care possible, your PCHC providers may view any portion of your medical record relevant to your treatment, which may include your physical or mental health records or your dental records.

1. **General Consent to Treatment:** By signing below, I authorize health care providers at PCHC to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care (including emergency treatment), services or therapies necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating health care provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. Before I undergo any procedures or tests, my provider(s) will explain the potential benefits, risks, or side effects, including potential problems that might occur during recovery, the likelihood of success, other options including relevant risks or side effects to those alternatives, as well as information about possible results of not choosing to undergo the recommended treatment. I understand that PCHC may obtain my photograph for inclusion in my medical records as part of my treatment.

2. **Right to Refuse Treatment:** In giving my general consent to treatment, I understand that I may refuse any examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my health care provider(s) and that I remain responsible for decisions about my own healthcare and the consequences of those decisions.

3. **Responsibility of Payment:** I understand that I must pay PCHC for any charges resulting from my treatment. I request that payment of authorized covered benefits be made on my behalf to PCHC for such services. I understand PCHC may release health information about me including information related to HIV/AIDS, substance abuse (except information limited by law), and mental health treatment to my health insurance carrier(s) in order to verify those benefits.

4. **Release of Health Care Information:** I understand that, subject to certain conditions, I may ask to limit disclosures, receive confidential information by giving PCHC an address, phone number or other means of receiving the information, see or obtain copies of my protected health information upon written request, and that I have other rights with respect to my health information as set forth in the Notice of Privacy Practices and listed in PCHC's "Authorization for Release of Health Care Information."

5. **Notice of Privacy Practices:** I understand that PCHC must keep my health information confidential, but legally may use my health information for purposes of treating me, getting paid for services provided to me, coordinating care for me, or for PCHC's necessary internal operations. I understand that a detailed list of allowed uses and disclosures is included in PCHC's Notice of Privacy Practices. **I have been offered a copy of PCHC's Notice of Privacy Practices and I**

   _____ TOOK A COPY _____ CHOSE NOT TO TAKE A COPY (please check one)

6. **Signature:** By signing below I agree that I have read and understand the information provided above. If I have any questions regarding my consent I will ask my provider before signing this form.

Patient Signature_____ **Date** _____

(If under 18, a parent or legal guardian must sign)

Witness Signature _____ **Date** _____