Consent for Treatment

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

This content shall remain in effect until further revoked in writing.
Your Privacy is of the 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 voicemail 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 your acknowledgment and/or authorization for each: (Please initial each line indicating understanding)

_____ 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 voicemail on the phone number(s) provided. These messages may contain Personal Health Information (PHI) such as the results of tests done here.

_____ I authorize the staff of the Partnership Health Center to leave detailed messages containing PHI to any person answering the below indicated phone number(s):

Authorized Phone Number(s): _____ or _____.

Please indicate the people that you wish to authorize to pick up prescriptions and/or refills or other medical supplies for you AND the people you authorize with whom the Partnership Health Center staff (including providers) may discuss your medical condition(s). This will include PHI. Please circle YES or NO for each person.

Authorized Person(s)	Relationship to you	RX Pick Up		Discuss PHI	
_____	_____	YES	No	YES	No
_____	_____	YES	No	YES	No
_____	_____	YES	No	YES	No

Signature: _____ Date: _____