Community Health Care, Inc.

COMMUNITY HEALTH CARE, INC. CONSENT FOR TREATMENT MINOR UNDER THE AGE OF 18

Patient _____ Birthdate_____ Chart #_____

I, _____, allow the providers and employees of Community Health Care, Inc. to assess and treat the needs of _____. This includes anything needed to diagnose the minor patient, any shots, or any treatments ordered by Community Health Care, Inc. providers. While giving care or while doing any lab procedures, the parent/guardian and/or CHC Staff may need to hold the child down. This could include use of the papoose board, holding the child's hands, upper body, head, and/or controlling leg movements.

- I have been given a copy of the Patient Bill of Rights and Responsibilities and have been able to ask questions about it. _____**(**initial).

- I have been given a copy of the Notice of Privacy Practices. I can get extra copies of the notice when I ask for one. _____(initial)

- After your visit we will give you a written health plan. We are not legally liable for the privacy of your information if you leave or lose it. _____(initial)

- I give Community Health Care my consent to leave detailed information on voice messages. This may include lab results, test results, form/records information, and medication information. This **WILL NOT** include mental health, substance use, sexually transmitted diseases, genetic testing, and HIV information. We will need to speak to you directly about this type of information.

  It is your responsibility to ensure we have your most current phone number on record.

  Please mark your choice to participate in receiving detailed voice messages.

  - ☐ Yes
  - ☐ No

  I know that I need to update the consent form if changes need to be made. This voicemail consent is valid until I tell CHC to cancel it. _____(initial)

- **Authorization to release information from CHC for school/work activities:**

  _____(initial)

  - This information can be released to patient's work/school for the purposes of participation of school functions to include but not limited classroom, sports, club, and other extra-curricular school sanctioned activities.
  - The information is to be limited to physicals, laboratory test results related to school, and vaccination information.
  - I understand that no information for mental health, substance use, sexually transmitted infections, genetic testing, or HIV will be provided. Those items require a separate release of information.
  - This information will be provided by mail, fax or to you for hand carrying. Please note once provided to you or the school/work CHC is no longer responsible if it is accessed at the school/work, or you leave or lose it.

(Continues on back

Patient _____ Birthdate_____ Chart #

- I further understand that this release is valid for one (1) year from the date of signature below.
- I may restrict or cancel this authorization at any time.
- If I do not sign below or cancel this release, CHC will not send the information but does not stop you from being seen for care at CHC.
- No medical records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirement (42 CFR Part 2) prohibit further disclosure without the specific written consent of the patient.

- **COMMUNICATION WITH FAMILY & OTHERS INVOLVED IN YOUR CARE**

  - Biological/Adoptive/ Legal parents are allowed to bring their children to appointments and obtain medical information about their children. To make these processes easier please list both parents:

    Legal Parent/Guardian #1 _____
    Legal Parent/ Guardian #2 _____

I understand I should make every effort to accompany my child to appointments. If I am unable to come to an appointment, I give permission to Community Health Care Physicians as follows (**Choose one):**

☐ **I will allow the following names listed below to consent for my child's treatment only. It does not allow release of records, that will require a separate signed release of information form for non-school records.**

NAME: RELATIONSHIP TO PATIENT	ALL	SCHEDULING/ APPOINTMENT	OFFICE VISIT	BILLING	DENTAL PAPOOSE BOARD	PRESCRIPTIONS	HIV INFO
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

Specific Instructions or Limitations: ___

- I understand that my child may not be seen if he arrives at the clinic with a care giver who does not meet the above chosen guidelines.
- I understand that a written permission note signed by me will always be acceptable as consent for any services included in the note.

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. For us to change your information please come in and fill out a new form. _____(initial)

_____ _____
(Patient's Name Printed) (Signature of Patient/Legal Representative)

_____ _____
(Relationship to Patient) (Date)