MOLOKAI COMMUNITY HEALTH CENTER

CONSENT & ACKNOWLEDGEMENT RENEWAL

DATE: _____

NAME: _____ **BIRTH DATE:** _____ **GENDER:** [ ] Male [ ] Female

MAILING ADDRESS: _____ **EMAIL:** _____

PRIMARY PHONE NUMBER: _____ **MARITAL STATUS:** [ ] Single [ ] Married [ ] Divorced [ ] Widowed

---

HOMELESS: [ ] Yes [ ] No **HOUSING STATUS:** [ ] Shelter [ ] Transitional [ ] Doubling Up [ ] Street [ ] Other

MONTHLY FAMILY INCOME: Before Deductions $_____ Family Size _____ [ ] Refuse to Provide

EMERGENCY CONTACT: _____ Relation: _____ Phone: _____

CONSENT TO TREAT:
I hereby authorize Molokai Community Health Center (MCHC) to render any health services/treatment that is deemed necessary, to me in accordance with the policies and procedures of MCHC. I understand that I retain the right to refuse any or all of the recommended health services/treatment.

CONSENT TO SHARE MEDICAL RECORDS:
I understand that my medical record could be shared within the different departments of MCHC. The information will be shared only to help in my health care assessment/management. I also understand that at any time during the course of receiving health services/treatment, a referral to a specialist is required, details from my medical record could be forwarded to the specialist. This will be done solely to assist in my complete evaluation.

I hereby authorize MCHC to release my medical record to be reviewed for the purposes of an auditor/evaluation to enhance patient care and to comply with managed care requirements. I understand that no identification of my name, date of birth or address will be recorded during this review process.

I understand that I can receive my medical records for personal use for a fee of $.50 per page if the medical record is over 10 pages.

CONFIDENTIALITY:
I understand that MCHC has a strict policy regarding privacy and confidentiality of my medical information. The Notice of General Patient Rights & Privacy Practices includes additional information about the use and disclosures of medical information. A copy is displayed in the waiting room and can be provided to you upon request.

MEDICAL INSURANCE AUTHORIZATION & ASSIGNMENT:
I hereby authorize MCHC to furnish information concerning my health services/treatment to my insurance carrier. I hereby also assign to MCHC, all the payments for my health services/treatment rendered. I understand that I am responsible for any amount not covered by my insurance.

ACKNOWLEDGEMENT:
I understand that this consent in its entirety will remain in effect as long as I continue to receive health services/treatment at MCHC. You have the right to revoke this consent provided in writing, except to the extent that we have already used or disclosed the information in reliance on the consent.

_____ _____

SIGNATURE OF PATIENT **DATE**

_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN (Must present proof of guardianship.) **DATE**