MOLOKAI COMMUNITY HEALTH CENTER

CONSENT & ACKNOWLEDGEMENT

TODAY'S DATE: _____

NAME: _____ **DOB:** _____

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

CONSENT TO SHARE MEDICAL RECORDS:
I understand that my medical records could be shared within different departments of the Molokai Community Health Center and between HIPAA compliant entities through a health information exchange system. The information will be shared only to help in my health care assessment and management.

I understand that information regarding any and all prescription drugs I am currently taking and/or have taken in the past may be shared between my providers and the pharmacy. This authorization may include disclosure of prescription details related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information.

I also understand that at any time during the course of receiving health services and 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 Molokai Community Health Center to release my medical record to be reviewed for the purposes of an auditor and/or evaluation. The purpose of this review is 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 a copy of 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 Molokai Community Health Center has a strict policy regarding privacy and confidentiality of my medical information. The Notice of General Patient Rights & Privacy Practices of the Health Center 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 Molokai Community Health Center to furnish information concerning my health services and treatment to my insurance carrier. I hereby also assign to Molokai Community Health Center, all the payments for my health services and 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 and treatment at Molokai Community Health Center. You have the right to revoke this consent provided that you do so 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**