Date: _______________

Consent for Treatment
Use of Protected Health Information

Patient name: ________________________________ **Date of Birth:**____________________
Address: _____________________________________ **Phone:** ____________________
Employee ID: _________________________________ **Work Site:** ____________________

I hereby consent to medical evaluations, testing, and /or treatment provided by the staff of this medical facility. I understand that prior to treatments, procedures or receiving medication and vaccines, I will be informed of the benefits, risks, and possible side effects and allowed to ask questions for full knowledge to give informed consent, and I understand that implied consent may apply in instances of serious illness, injury or altered mental status. I understand it is my responsibility to provide any information relevant to health history, possible medication interactions and allergies. I understand that the screening procedures may consist of tissue penetration (fingerstick or drawing of blood) for analysis by laboratory equipment. I acknowledge that I am eighteen (18) years of age or older and have carefully read and understand this information.

I willingly consent to participate in this screening program. I release Lake Charles Urgent Care and/or Family Physicians Urgent Care, its officers, director, associates, and all persons acting on its behalf from all claims and demand, damages, rights and causes of action of any kind the undersigned may have on account of, or in any way growing out of the personal injuries/damages known or unknown to me because of this screening.

I understand that the provider may use telemedicine and video technologies, and photographs of my injury or wound, etc. for treatment, consultation, or specialist referrals. I understand that I may be referred to a health care provider for follow-up care and that I will be given the freedom of choice in the referral selection. If I do not have an established health care provider and have no preference in selection, I understand that my PHI may be sent to an affiliated health care organization to follow up with me to help coordinate my care. I understand that my insurance may not cover the services for which I am being referred and that I should verify coverage with that provider prior to my visit.

I understand that the company may use or disclose my Protected Health Information (PHI) necessary to carry out treatment, payment, or healthcare operations or in other instances as permitted by HIPPA. I opt to authorize the company to use and disclose my PHI utilizing health information exchange portals for continuity of care. I understand that the contact information I provide such as my physical address, phone number and email may be used to provide me with information on health-related benefits and services that may be of interest to me, to provide me with marketing and fundraising material and to send me patient satisfaction surveys. I acknowledge and agree to my survey feedback being used on an anonymous basis on the website or other public sites to identify comments that the public may view and objectively review. I understand that I have the right to opt out of or unsubscribe to any information, materials, or survey that I may receive.

I have been given the opportunity to ask questions, to file a complaint to have my concerns addressed, to submit a special written request and to object to the release of my PHI to a specific person if I so choose.

X______________________________
Signature of person giving consent

B/P: _____________ HT: _________
Abd Circ : ________ WT: _________