COMMUNITY HEALTH

MEDICAL • DENTAL • BEHAVIORAL HEALTH

MEDICAL RECORDS
71 Allen Street, Suite 402, Rutland, VT 05701
Phone 802-671-5800 | Fax 802-772-7973
CHCRR.org

MEDICAL CONSENT

For Treatment, Release of Information and Assignment of Insurance Benefits

A. I authorize and give my consent to Community Health, their agents, employees, and to all medical personnel, including but not limited to physicians, nurses, technicians and healthcare staff and providers at Community Health (all of the aforementioned herein collectively referred to as "Community Health Healthcare Providers") for all examinations, diagnostic procedures, surgical procedures, care and/or treatment prescribed for me. I authorize the sharing of my medical information with Community Health Teams that have been established to help assess my needs, coordinate community based support services, and provide multidisciplinary care. I acknowledge that no representations, assurances or guarantees have been made to me regarding the effects or results of any examination, evaluation, care and/or treatment to be rendered to me.

B. I authorize Community Health to communicate either verbally or in writing information which is medically necessary for my child to attend school.

C. I consent to the disclosure of my prescription medication information by any provider, mental health provider, pharmacy, insurer or prescription benefits manager, specifically including any state or federal health benefits program, to Community Health Healthcare Providers for the purpose of my treatment. My consent includes the redisclosure of prescription medication information received from a drug or alcohol treatment program.

D. I authorize Community Health to disclose my protected health information, including the diagnosis and copies of records of any treatment or examination rendered to me or my dependent during the period of such case, to third party/payers and or other health practitioners. I authorize my insurance company to make all payments for covered services directly to Community Health, my physician and Community Health Healthcare Providers for the services billed by them and hereby assign my rights to such insurance company payments to them. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf, or my dependents in accordance with my health care plan that Community Health is entitled to collect. I understand that all of my bills will be sent to the responsible party who is named on my account.

E. For the purpose of advancing medical education, I authorize the attendance of healthcare students participating in Community Health programs.

F. I authorize Community Health Healthcare Providers to appropriately dispose of any specimens/tissues taken from my body, or, as applicable, sent to pathology for evaluation in agreement with my designated healthcare provider. Once disposed of, these specimens/tissues cannot be retrieved.

G. I authorize and give consent to Community Health Healthcare Providers involved in my care, to access, use and disclose among themselves and to others my Protected Health Information for my care and treatment and disclose it to my insurance carriers and others for payment for my care and treatment.

H. I authorize Community Health Healthcare Providers to electronically forward my medication prescriptions to the pharmacy I designate.

I. If I have a work-related incident/injury, I authorize Community Health to release information to my employer as deemed necessary for payment of services rendered.

J. I agree that in order for Community Health Healthcare Providers to service my account or to collect any amounts owed to them that they, or their agents, may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me and by sending text messages, or e-mails, using any e-mail address provided to them. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

K. I certify that the information given by me to obtain any payment under Medicare is correct. I authorize any holder of medical, Protected Health Information, or other information about me to release it to the Social Security Administration or its intermediaries or carriers for this or any related Medicare claim. I request that payment of my authorized benefits be made by Medicare to Community Health Healthcare Providers on my behalf.

L. I consent to treatment at any Community Health office. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. I understand that I have the right at any time to discontinue services with Community Health.

M. This consent is subject to my written revocation at any time except to the extent it has already been acted on.

N. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

O. I understand and agree that Community Health may at its discretion provide certain services to me by remote means called "telehealth". Such telehealth services improve access to medical care and involves a health provider who is at a site remote from my location at the time of the service. Telehealth may involve the secure transmission of video, audio, images, pictures and other types of information in real time or via a store and forward application. The remote provider will determine whether the condition being diagnosed or treated is appropriate for telehealth. I understand that I will be informed of the presence of any other individual who will be participating in or observing my consultation.

Print Name of Patient	Patient Date of Birth
Signature of Patient, or if minor, as applicable, Parent/Guardian/Loco Parentis	Date

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have been offered Community Health's Notice of Privacy Practices dated September 22, 2022. I acknowledge and agree to the terms of Community Health's Notice of Privacy Practices. I understand that if I have questions, I should contact the Community Health Corporate Compliance & Patient Relations Manager, 71 Allen Street, Suite 101, Rutland, VT 05701, 802-855-2097, patientrelations@chcrr.org.

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