Family Health Care of Northwest Ohio, Inc.
1191 Westwood Drive
Van Wert, OH 45891
Phone: 419-238-0248 Fax: 419-238-3721

CONSENT TO USE & DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

Patient
Name_____DOB_____SS#_____

Permission to Use & Disclose Your Health Information. By signing this consent, you authorize us to use and/or disclose your health information for treatment, payment or health care operations. You have the right not to sign this consent. However, if you refuse to sign this consent, we have the right to refuse to treat you.

Right to Review Notice of Privacy Practices. You have the right to review a copy of our Notice of Privacy Practices before signing this consent or after any revisions. Our Notice of Privacy Practices details how we may use and disclose your health information. We may amend the notice from time to time.

Right to Request Restrictions on Use/Disclosure. You have the right to request, in writing, that we restrict how we use and/or disclose your protected health information for the purpose of providing treatment, obtaining payment for our services, and/or conducting health care operations. Please note that we are not required to agree to any restriction you may request. If, however, we decide to agree to a restriction you have requested, we must restrict our use and/or disclosure of your health information in the manner described in your request.

Right to Revoke Consent. You have the right to revoke this consent at any time, in writing. Note that your revocation of this consent will not be effective for disclosures we have already made in reliance on your prior consent. We also have the right to refuse to provide further treatment if you revoke this consent.

Right to Receive a Copy of This Consent Form. You have a right to receive a copy of this consent form after you sign it.

Effective Period. This consent is effective until you revoke it, in writing.

I have read and understand this consent and hereby authorize **Family Health Care** to use and/or disclose my health information for treatment, payment, or health care operations.

Patient's
Signature/Representative_____Date_____

Printed Name of Patient's
Representative_____Relationship_____

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Please complete the back side of this form

Effective 3/29/2007
Revised 11/21/16

Consent for Information / Treatment

Adult Patients (18 and over)

I authorize Family Health Care Medical & Dental Staff to give information concerning my health care (personal health information, appointment times, test results, etc.) **to the following people**:

Name(s)_____Relationship to Patient_____

Name(s)_____Relationship to Patient_____

Name(s)_____Relationship to Patient_____

If no one should receive information about your health care, please write "NONE".

Patient Signature_____Date_____

Name & Relationship to Patient (if signed by patient representative)_____

Only person(s) listed on this form will be able to receive information from Family Health Care staff about you. There will be no exceptions.

Minor Patients (Children 0-17 years)

Mother_____Father_____
(or legal guardians)

Due to HIPAA regulations, we are not permitted to give out medication information (personal health information, appointment times, test results, etc.) about your child to anyone except his or her **parents or legal guardians.** If someone other than a parent or legal guardian should have authorization to access this information, please indicate who on the lines below: (Grandparents, aunt/uncle, baby sitter, etc). Please also indicate who may give c**o**nsent for MEDICAL AND DENTAL treatment (including tests, immunizations, etc.).

Name(s)_____Relationship to Patient_____
- ☐ Consent for information
- ☐ Consent for authorization of medical/dental treatment

Name(s)_____Relationship to Patient_____
- ☐ Consent for information
- ☐ Consent for authorization of medical/dental treatment

Name(s)_____Relationship to Patient_____
- ☐ Consent for information
- ☐ Consent for authorization of medical/dental treatment

Name(s)_____Relationship to Patient_____
- ☐ Consent for information
- ☐ Consent for authorization of medical/dental treatment

Parent/ Legal guardian's Signature_____Date_____

Printed Name _____Relationship_____

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