Dental: 450 West River St, Orange, MA 01364
Phone: (978) 544-1576 ● Fax: (978) 544-0024
Medical: 450 West River St, Orange, MA 01364
Phone: (978) 544-7800 ● Fax: (978) 544-0023

CHCFC
Community Health Center of Franklin County

Community Health Center of Franklin County

Patient Consent for Health Information Exchange

PATIENT INFORMATION (Please Print Clearly)

_____ _____ _____
Last Name **First Name** **Middle Initial**

_____ _____ _____
Date of Birth (mm/dd/yyyy) **Medical/Dental Record Number** **Phone Number**

_____
Home Address: City, State, Zip Code

PATIENT CONSENT FOR HEALTH INFORMATION EXCHANGE

By agreeing to **GIVE CONSENT** below, I hereby authorize any of the parties designated on the next page to communicate with one another about me verbally, in writing, or via electronic information exchange. Such communication may include requesting, receiving, providing, and using my medical/dental information. I understand that the purpose of communicating about me is to allow the parties to evaluate my needs, provide services to me, and coordinate my care. I further understand that I may be required to sign additional consent forms to be eligible for insurance coverage and payments or certain types of treatments and services.

I understand that my medical/dental information will include all pertinent information from my medical/dental record as described here:

- My name and other personal identifying information.
- My identity as an applicant for or recipient of healthcare services, which may include substance use disorder and/or mental health services.
- The contents of my medical/dental record, which may include:
  - Problems/diagnoses.
  - Visit/discharge/examination assessments and summaries.
  - Laboratory/x-ray tests and results.
  - Medications.
  - Procedures.
  - Family/social history.
  - Other information about my health.

- My medical/dental record may include information about the following conditions and treatment:
  - Mental health.
  - Substance use disorder.
  - Sexually transmitted diseases.
  - Pregnancies/abortions.
  - Domestic abuse.
  - Rape/sexual assault.
  - Genetic diseases, testing, and test results.
  - Mammograms.
  - Other information about my health.

I understand I have the right to exclude certain types of health information from being exchanged. I exclude the following:

_____

_____

I understand that certain federal laws, including the Health Information Portability and Accountability Act (HIPAA), allow providers and other healthcare organizations to exchange much of my health information without my consent in order to provide me with treatment, receive payment for my care, and manage and coordinate my care. I further understand that my healthcare providers are permitted or required by law to provide some of my medical/dental information without my consent to other healthcare providers, public health agencies, and law enforcement for purposes including but not limited to medical/dental emergencies, quality reporting, audits, crimes against persons and property, and certain legal orders. I understand that *Community Health Center of Franklin County* is not responsible for authorized or unauthorized re-disclosure of my health information by receiving providers.

Community Health Center of Franklin County

Patient Consent for Health Information Exchange

PATIENT CONSENT FOR HEALTH INFORMATION EXCHANGE (Continued)

I understand that the following healthcare providers, including their staff, employees, and contracted entities, may provide or receive my medical/dental information for the purposes of evaluating my needs, providing services to me, and coordinating my care. I understand that only the providers who need to coordinate a particular aspect of my care will provide or receive information about that aspect of my care. ☐ **Transferring Records to CHCFC** ☐ **Transferring Records from CHCFC**

☐ List specific provider(s) / practice(s) *Attach additional sheets if needed* _____ _____ Prior PCP **(Incoming Records Only):** _____	**Records to be Disclosed:** ☐ Medical ☐ Dental ☐ Other:	**Type of Records:** ☐ Entire record ☐ Immunizations only ☐ Other:	**Period of Information:** ☐ Entire period of care

CHCFC OFFICE USE ONLY: ☐ **CHD** ☐ **BFMC** ☐ **ATH/HWH**

☐ General designation

I understand that any of my treating providers may provide or receive my medical/dental information for treatment purposes. I understand that I have a right to obtain, upon request, a list of entities to whom my medical/dental information has been disclosed (List of Disclosures), pursuant to the general designation.

☐ I give permission to share information from my medical/dental record about HIV antibody and antigen testing with:

_____ _____ _____

Print name of facility and provider *Patient Initials* *Date*

I understand that my healthcare providers may communicate my information by any means, including verbally, by paper, by fax, by secure electronic transmissions, and by the Massachusetts Health Information Highway (the Mass HIway).

MY CONSENT CHOICE

I understand that I have the right to receive a copy of this consent form.

☐ **I GIVE CONSENT**. By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily, and without coercion. I understand that I have the right to revoke this consent at any time; however, any information that was already exchanged cannot be taken back. If I have not revoked this consent, it will expire when one of the following conditions is satisfied. Choose one:

- ☐ Consent expires one year after the **Effective Date** of this consent (below)
- ☐ Consent expires on this date:_____
- ☐ Consent expires upon this condition or event:_____

☐ **I DENY CONSENT**. By my signature below, I acknowledge that I have denied consent for my healthcare providers to communicate my health information to one another. I acknowledge that by denying my consent, my healthcare providers may have limits on their ability to provide and coordinate my care.

_____ _____

Signature of Patient **Effective Date**

_____ _____

Signature of Patient's Legal Guardian or Authorized Representative **Effective Date**

_____ _____

Print Name of Legal Guardian or Authorized Representative **Description of Authority** *if signed by Legal Guardian or Authorized Representative*

_____ _____

Signature of Translator (if applicable) **Printed Name of Translator (if applicable)**