

CONSENT TO TREATMENT

I (the patient/guardian/legal representative to the patient acting on the patient’s behalf) give permission for medical treatment, including radiological and laboratory procedures, to be performed by the physicians and staff of Covenant Medical Group. **PHARMACY/MEDICATION HISTORY:** I authorize Covenant Medical Group to obtain all of my medication history, in any format, to provide my medical care.

This consent is valid from this date forward.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed Covenant Medical Group’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

ADVANCED DIRECTIVE LIVING WILL

Do you have an advanced directive/living will? Yes No

If you answered No, would you like more information on Advanced Directives? Yes No

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA (Health Insurance Portability and Accountability Act) privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (PLEASE PUT A IN EACH SECTION):

- | | |
|--|---|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> Leave a message with detailed information
<input type="checkbox"/> Leave a message with call back number only
<input type="checkbox"/> Please do not leave a message

<input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> Leave a message with detailed information
<input type="checkbox"/> Leave a message with call back number only
<input type="checkbox"/> Please do not leave a message

<input type="checkbox"/> Mobile Telephone _____
<input type="checkbox"/> Leave a message with detailed information
<input type="checkbox"/> Leave a message with call back number only
<input type="checkbox"/> Please do not leave a message

<input type="checkbox"/> Fax Number: _____
<input type="checkbox"/> Please do not fax any information to me | <input type="checkbox"/> Written Communication
<input type="checkbox"/> Mail to my home address
<input type="checkbox"/> Mail to my work/office address
<input type="checkbox"/> Please do not mail

<input type="checkbox"/> The following people may have access to my medical information:
<input type="checkbox"/> Spouse/Significant Other: _____
<input type="checkbox"/> Child: _____
<input type="checkbox"/> Child: _____
<input type="checkbox"/> Child: _____
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Nobody should have access |
|--|---|

The above authorized information will apply to all Covenant Medical Group providers and remains in effect until additional notice or changes are made by the patient.

Relationship to Patient: Self Child Dependent Other: _____

Printed Name Birthdate Signature Date

Printed Name of Witness Signature of Witness Date