Patient Privacy

Your medical information is personal and private. We are committed to protecting it. Our HIPAA notices, privacy policies, and patient bill of rights & responsibilities can be found on our website and posted in our lobby. They are also made available to you in print upon request from our staff.

How we share your personal health information:

1. **To share with you:** Upon your request, you have a right to access your health records as defined in 45 CFR 164.501 as a designated record set.
2. **For care or treatment purposes:** We may consult with other medical professionals on our team and share your health information. We may also work with outside providers and share your health information for coordinating care.
3. **For payment:** Your insurance or payer may require us to share some of your health information in order to cover your services. You may restrict the disclosure of your health information to your insurance or payer for payment and then be responsible for these charges.
4. **For business operations:** We may share limited and primarily de-identified health information for quality assessment purposes, licensing, and other business needs. Any outside parties with which we partner have written contracts requiring the protection of the privacy of your health information.
5. **Required public health reporting:** The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability.
6. I authorize Catherine's Health Center to access my immunization record history in the Michigan Care Improvement Registry (MCIR) to coordinate records for immunizations and to meet State of Michigan requirements for immunization reporting.
7. I authorize Catherine's Health Center to download my medication history automatically from pharmacy benefit managers (PBMs) as available and necessary.

You may choose to request additional restrictions on the use and disclosure of your protected health information and/or for additional confidential communication. Please ask our staff for documentation to complete.

____ ______________

Full Legal Name of Patient (Please Print) Date

____ ______________

Patient/Guardian Signature (Legal Name) Date

I authorize Catherine’s to release limited medical information to the following individuals:

Name:	Phone Number:	Information to Release:
Name:	Phone Number:	Information to Release:
Name:	Phone Number:	Information to Release:
Name:	Phone Number:	Information to Release:
Name:	Phone Number:	Information to Release:

☐ **Yes** ☐ **No** Catherine’s may leave detailed messages on my voicemail about upcoming appointments (if marked “no,” we will leave our name, phone number, and request a call back)

☐ **Yes** ☐ **No** Catherine’s may leave detailed messages on my voicemail from the clinical team about my health (if marked “no,” we will leave our name, phone number, and request a call back)

Patient/Guardian Signature (Legal Name) ______________________ Date ____________

OFFICE USE ONLY

If it is not possible to obtain the individual’s acknowledgment of our privacy practices, describe in the box below the good faith efforts made to obtain the individual’s acknowledgment and the reasons why the acknowledgment was not obtained.

Write your response here:

Signature of Center Representative ______________________ Date ____________

Consent to Treatment

I authorize Catherine's Health Center (Catherine's) and its medical, nursing, and other professional staff members to provide services. I authorize Catherine's professional staff members to administer such diagnostic and therapeutic procedures and treatments, as in the judgment of Catherine's medical personnel, deemed necessary or advisable in my care.

I understand that all medical evaluation and treatment includes a degree of risk. I have the right to inquire about the risks and benefits associated with recommended testing and treatment.

I understand that this Consent to Treatment is valid for each visit I make to Catherine's until revoked by me in writing.

Full Legal Name of Patient (Please Print) ________________ Date ________

Patient/Guardian Signature (Legal Name) ________________ Date ________