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 of our staff.

How we share your personal health information:

1. **To share with you:** Upon your request, you may always access your own health records in their fullness.
2. **For care or treatment purposes:** We may consult with other medical professionals on our team and share your health information. This disclosure is only for the purpose of your care plan. Your authorization is always required to share any health information with another medical professional not on staff with us.
3. **For payment:** Your insurance or payer may require us to share some of your health information in order to cover your services. If you are uninsured, you may restrict the disclosure of your health information for payment.
4. **For business operations:** We may share health information for quality assessment purposes, licensing, and other business needs. Any outside parties, such as licensing body, have written contracts to protect the privacy of your health information.

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.

Full Name of Patient & Signature ______________________ Date ____________

Catherine's may release medical information to the following individuals:

Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

☐ **Yes** ☐ **No** Catherine's may leave detailed messages on my voicemail in regard to upcoming appointments (if no, we will leave our name, phone number, date & time of appointment)

☐ **Yes** ☐ **No** Catherine's may leave detailed messages on my voicemail from the clinical team in regard to my health (if no, we will leave our name, phone number, date & time of appointment)

Patient/Guardian Signature ______________________ Date __________

OFFICE USE ONLY

If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment and the reasons why the acknowledgment was not obtained.

Name & 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 health care 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, is deemed necessary or advisable in my care.

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

Catherine's offers care in an integrated setting. Some health information is specially protected. I understand that I must give consent to share this information in some cases. This information includes HIV/AIDS status, sexually transmitted infections (STIs), tuberculosis (TB), Hepatitis B, genetic information, and behavioral health and substance use disorder information.

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

Full Name of Patient ______________________ Date __________

Patient/Guardian Signature ______________________ Date __________