North Coast Health
A faith-based charitable clinic

216.228.7878 | northcoasthealth.org
16110 Detroit Avenue | Lakewood, OH 44107

# Consent and Authorization

Patient Name: ______________________ Date of Birth: ______________

Social Security #: ______________________ Phone Number: ______________

Address: ________________________________________

## Consent for Treatment

I consent to the use or disclosure of my protected health information by the staff and volunteer medical care providers of North Coast Health (NCH) for the purpose of diagnosing or providing treatment and services to me, obtaining payment for my health care bills or to conduct health care operations of NCH. I understand that diagnosis or treatment of me by NCH may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. NCH is not required to agree with the restrictions that I may request. However, if NCH agrees to a restriction that I request, the restriction is binding on NCH.

I have the right to revoke this consent, in writing, at any time, except to the extent that NCH or its volunteers has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review NCH's Notice of Privacy Practices prior to signing this document. The NCH's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the NCH. The Notice of Privacy Practices for NCH is also provided in the office of NCH. This Notice of Privacy Practices also describes my rights and NCH's duties with respect to my protected health information.

NCH reserves the right to change the privacy practices that are describes in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Initial: ________ Date: ________

## Voluntary Care Patient Consent Form

I hereby consent to the provision of diagnosis, care, and/or treatment by North Coast Health, and I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing.

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the diagnosis, care and/or treatment and am not subject to duress or undue influence.

**I hereby acknowledge and understand that, by signing this voluntary care patient consent form, I am giving informed consent to the provision of diagnosis, care, and/or treatment by North Coast Health and cannot bring a tort or other similar action, including an action on a medical, dental, chiropractic, optometric, or other health-related claim, against the treating practitioners, clinic health care workers and other workers associated with North Coast Health unless the action or omission of North Coast Health constitutes willful or wanton misconduct.**

## Authorization for Release of Information

I give my permission to North Coast Health (NCH) to send any and all medical records necessary for the continuation of care to any referral physician or medical institution. I understand that this authorization applies to any and all of my medical information, history, records, diagnoses and reports of x-ray, rendered to me at any of the clinics and / or referral physicians affiliated with NCH. These records may include the diagnosis and treatment of alcohol / chemical dependency or HIV, AIDS, or any AIDS related condition.

I further understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at 16110 Detroit Avenue, Lakewood, OH 44107. I understand that a revocation is not effective to the extent that action has been taken in reliance thereon.

Without express revocation, this consent is valid until the records have been released or for one hundred eighty (180) days from the date of signature, whichever comes first. A photocopy has the same authority as the original. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use of disclosure except (1) If my treatment is related to research, or (2) Health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I hereby authorize North Coast Health to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor or to an appropriate insurance carrier. If Medicare or Medicaid patient, I further authorize release to the Center of Medicare and Medicaid Services and its agents any information needed to determine benefits payable for related charges. I hereby assign or transfer payment benefits made to me and my behalf to North Coast Health for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me.

Signature of Patient or Personal Representative* Date

** If this consent is signed by someone other than the patient, it must be signed in the patient's presence.*

Description of Personal Representative's Authority and/or Relationship to Patient (if applicable)

North Coast Health Witness Date