OnSite Clinics

CONSENT FOR TREATMENT

I authorize and consent to physical examination and receipt of healthcare services including, but not limited to: diagnostic procedures and medical treatment necessary to my care, health coaching and wellness screening services.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

_____ I have read and understand the above statement.
Initial

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Goshen Hospital Notice of Privacy Practices with the effective date of May 19, 2003. I further acknowledge that Goshen Hospital may provide limited health information about me to my personal health record as further described in the Notice of Privacy Practices.

_____ I have read and understand the above statement.
Initial

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I agree a copy of this form may be treated as a signed original. I accept responsibility for providing the correct physician recipient information to Goshen Hospital/Goshen Physicians as described below.

Patients Name: _____ Date of Birth: _____/____/_____
Address: _____ City: _____ State: _____ Zip:_____
Phone: _____ Email: _____

I hereby authorize: Goshen Community Schools Health and Wellness Center
601 E. Purl Street; Goshen, IN 46526

To release to: Provider's Name:_____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (_____)_____ Fax: (_____)_____

The following information:

_____
_____

_____ _____ _____
Printed Name of Patient/Guardian or Representative | Signature of Patient/Guardian or Representative | Relationship to Patient

Witness Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures of Health Information

A. With your consent, we may use health information about you for treatment (such as sending your medical record information to a specialist physician as part of a referral), to obtain payment for treatment (such as sending billing information to a health insurance plan), for administrative purposes, and to evaluate the quality of care that you receive (such as comparing patient data to improve treatment methods).

B. We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, abuse or neglect reporting, auditing purposes, research studies, funeral arrangements and organ donation, workers compensation purposes, and emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also contact you about appointment reminders or treatment alternatives or to raise funds. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

C. We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area, in each examination room, and on our Web site. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

A. In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

B. You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice was sent to you electronically, you may obtain a paper copy of the notice.

C. You may request in writing that we not use or disclose your information for treatment, payment, or administrative purposes or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. Under no circumstance will you be retaliated against for filing a complaint.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Effective date is May 19, 2003.

If you have any questions or complaints, please contact:

Alan Weldy, Privacy Officer
200 High Park Ave.
Goshen, IN 46526
(574)-535-2898 email: privacyofficer@goshenhealth.com