EWHC's Consent for Treatment and Acknowledgment of Receipt of Notice of Health Information Privacy Practices and Consent to Disclosures

Name of Patient: _____ Today's Date: _____

Date of Birth: _____ Phone: _____

As a patient of the Eastside Women's Health Center and by signing below:

I hereby authorize Eastside Women's Health Center to provide care, perform general diagnostic procedures and exams as necessary to facilitate my diagnosis and treatment.

I understand that I may ask questions regarding my diagnosis, treatment, fees, and insurance coverage, or any other aspect of my care before signing this form. With this knowledge, I voluntarily consent to the policies and procedures of Eastside Women's Health Center.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during visits. I understand that free interpretive services may not be available and that I may be referred to another health care facility to provide the services necessary for my care.

No guarantee has been or will be given to me as to the results that may be obtained from any services I receive. I know that it is my choice to obtain these services and that I may change my mind about receiving medical care from Eastside Women's Health Center at any time.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive test results to the public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if a referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by a representative or me, or otherwise permitted or required by law.

I understand that I have the right to review my record and obtain a copy of my record upon request (see *Notice of Privacy Practices*) and that obtaining a copy of my record may require payment of a fee.

I hereby certify that I have reviewed the *Notice of Privacy Practices* for Eastside Women's Health Center that is available on the website**.** I understand that if I have objections or concerns with this policy, I must notify Eastside Women's Health Center.

_____ *Today's Date* _____

Patient Name (printed)

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