Aguilar Family Health Care

PATIENT CONSENT FORM

For Treatment, Payment, Health Care Operations & Release of PHI

Name of Patient_____ DOB_____

GENERAL INFORMATION As a patient of Aguilar Family Health Care (AFHC), when you seek medical advice or receive medical care from us, Protected Health Information (PHI) will be generated about you. This information includes your medical information (past, present and future) and personal information such as your name, address and social security number. This information will be used for the Treatment of you medical condition(s), obtaining Payment from your insurance company and for Healthcare Operations (TPO) within Aguilar Family Health Care.

NOTICE OF PRIVACY PRACTICES For a description of how your Protected Health Information may be used and disclosed, you may review Aguilar Family Health Care's "Notice of Privacy Practices" prior to signing this consent. Aguilar Family Health Care reserves the right to change the notice and will notify all patients of such changes prior to effective date.

PATIENTS RIGHTS You have the right to request a restriction of the uses and disclosures of your Protected Health Information (PHI) for the purpose of your treatment, payment for your services and the healthcare operations of Aguilar Family Health Care, We are not required to agree to the requested restrictions but we are bound by any restrictions agreed upon.

PERMISSION TO RELEASE YOUR PROTECTED HEALTH CARE INFORMATION TO FAMILY MEMBERS OF OTHERS

Please indicate below the person's name(s) to whom you authorize us to release medical and/or insurance information.

NAME_____ Date of Birth_____ Relationship_____

NAME_____ Date of Birth_____ Relationship_____

NAME_____ Date of Birth_____ Relationship_____

Aguilar Family Health Care has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent. In addition, Aguilar Family Health Care is authorized by law to use and/or disclose your PHI in certain circumstances without your consent.

Your signature below acknowledges:

- You have read and understand this consent.
- You agree to have your protected health information used and disclosed by Aguilar Family Health Care for the purpose of your treatment, to secure payment for your treatment, and for Aguilar Family Health Care operations.
- Prior to signing this consent, you were given the opportunity to review Aguilar FHC'S "Notice of Privacy Practices"
- You are permitting the release of your protected health information to the persons noted above.
- You are aware that you may now or at any time request restrictions to the use and disclosure of your protected health information.

SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE: X_____

DATE: _____

PRINTED NAME:_____