SCCHC Medical Record #_____

South Cove Community Health Center

Patient Consent for Purposes of Treatment, Payment, & Healthcare Operations

Patient Name	Date of Birth

I, the undersigned, being either the patient or the patient's legally authorized representative, do hereby:

GENERAL CONSENT FOR TREATMENT

- Give consent to and authorize the staff of South Cove Community Health Center (SCCHC) and its affiliated providers, contractors, and vendors (i.e. laboratories, hospitals) to provide medical treatment and/or evaluation, including but not limited to laboratory testing, imaging examinations, and general procedures.
- Understand that this consent will be in effect for today and all future treatment/evaluation at SCCHC.
- Understand that separate consents will be requested for certain special procedures.

ASSIGNMENT OF BENEFITS

- Give consent and authorize payment directly to SCCHC for services rendered at the facility and/or for services rendered off-site by SCCHC and its affiliated providers, contractors, and vendors for care and treatment. Any services for which assignments are accepted but are not covered under my insurance policy are acknowledged as being my full and complete financial responsibility.

USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION

- Give consent to use and disclose my protected health information by SCCHC and its affiliated providers, contractors, and vendors for the purpose of providing care and treatment to me, obtaining payment for services provided to me and conducting health care operations.
- Give consent and authorize SCCHC and its affiliated providers, contractors, and vendors to view my external prescription history up to several years via RxHub services or other means.
- Understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment, or our health care operations. SCCHC is not required to agree to the restrictions that I may request, but if it does, it is bound by its agreement.

ADDITIONAL INFORMATION

I have received a copy of the

- South Cove Community Health Center's Patient Rights and Responsibilities
- South Cove Community Health Center's Notice of Privacy Practices

I understand that it is my responsibility to read the information, and ask any questions that I may have.

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that South Cove Community Health Center has taken action in reliance on this Consent.

Signature Of Patient or Personal Representative	Print Name	Date
Relationship Of Personal Representative To Patient	**If Signed By Other Than Patient, State Reason, Attach Documentation**	

SCCHC Medical Record #_____

華人醫務中心

有關治療、付費和健康保健程序的同意書

病人姓名	出生日期

本人作為病人或病人的法定受託人特此在以下簽署：

對於治療的大致同意：

- 允許及授權華人醫務中心的醫護人員，以及其他參與治療的醫生、提供服務的機構（例如：檢驗室、醫院等）提供醫療和/或評估、包括但不局限於實驗室測試、影像學檢查，以及一般的程序；
- 明白到本同意書將有效於今天以及將來所有在華人醫務中心進行的治療或評估活動；
- 理解對於特別的程序將需要簽署另外的同意書。

有關利益的分配：

- 同意及授權有關機構直接向華人醫務中心的醫護人員，以及其他參與治療的醫生、提供服務的機構，支付本人在該中心或中心以外的地點所接受治療的款項。本人確認，所有已接受但又不在保險單承保範圍內的服務，將由本人完全承擔財務上的責任。

有關使用與分享本人保密的健康資料：

- 同意華人醫務中心的醫護人員，以及其他參與治療的醫生、提供服務的機構使用與分享本人保密的健康資料，便於為我提供治療、獲取治療費用、以及進行健康保健活動；
- 同意華人醫務中心的醫護人員，以及其他參與治療的醫生、提供服務的機構通過RX系統或其他途徑瀏覽本人過去幾年在外的處方資料；
- 明白本人有權在治療、付款或健康保健活動中要求限制個人保密健康信息的使用與分享。華人醫務中心可以不接受本人可能提出的限制要求，一旦接受，中心將受該協議的約束。

附加資料

本人已收到以下資料的副本:

- 華人醫務中心病人權利與責任書
- 華人醫務中心私隱權通知書

本人明白有責任去閱讀所有資料，并及時提出疑問。

本人明白有權在任何時候以書面形式撤銷該同意書，華人醫務中心已根據同意書採取行動的情形除外。

病人或病人的法定受託人簽署	姓名	日期
法定受託人與病人關係	**如非病人簽署, 請列明原因及提供法律證明文件**	