R.O.A.D.S.
COMMUNITY CARE CLINIC

Consent to Treatment and Consent to Release of Health Information for Treatment, Payment and Health Care Operations

I. **Consent to Treatment**

I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian who has the right to consent to treatment for the named patient) to ROADS Community Care Clinic. Treatment may include health screening, diagnosis, medical treatment, dental care: social services; and/or mental health and drug and alcohol screening, assessment, diagnosis and treatment.

II. **Consent to Release of Health Information, including Health/Treatment Records for Treatment, Payment and Health Care Operations**

I consent to the use within ROADS Community Care Clinic and the disclosure to persons or organizations outside of ROADS Community Care Clinic of my (or of the named patient for who I am the parent or legal guardian) medical, dental, drug and alcohol, mental health and other treatment and health records and information (such health records and information are referred to in this Consent as my "Health information") by ROADS Community Care Clinic for the following purposes;

a) Use of Health Information by or For ROADS Community Care Clinic for treatment and for Health Care Operations:

- Providing treatment by ROADS Community Care Clinic staff:
- Conducting health care operations of ROADS Community Care Clinic including, for example, financial or quality assurance audits and training

b) **Disclosure of Health Information to Persons Outside ROADS Community Care Clinic for treatment purposes and for payment**

- Providing all necessary Health Information as determined by ROADS Community Care Clinic, including information about treatment for drug or alcohol abuse, to any health providers if I am referred there for treatment
- Providing Health Information to other health providers or agencies who may be involved in my care
- Obtaining payment for health care bills, including sending such Health Information as is needed to secure payment for ROADS Community Care Clinic services to the insurance company or agency that pays for my health services, as identified in my Registration Form or other updated insurance information on file with ROADS Community Care Clinic.

III. **Other Matters**

I understand that I have the right to revoke this Consent at any time, but revoking this Consent will not affect any actions which were taken by ROADS Community Care Clinic in reliance on this Consent before I revoked it. If not previously revoked, this consent will terminate on the following date, event, or condition: _____.If none is indicated, this consent will terminate three years after the last date of services to me.

I understand that I may request restrictions on use or disclosure of my Health Information for the purposes described in this Consent and ROADS Community Care Clinic may or may not agree to the requested restrictions. I also understand that except for those restrictions on use or disclosure of Health Information to which it agrees, The R.O.A.D.S Foundation will not be able to provide services to me (or the named patient) without this signed Consent.I understand and acknowledge that I am financially responsible for any unpaid balances incurred as a result of my care at ROADS Community Care Clinic.

R.O.A.D.S.
COMMUNITY CARE CLINIC

CONSENT TO DISCLOSE HEALTH INFORMATION

I, _____. Date of birth:_____

(Name of patient whose information is being requested)

Authorize_____

(Name and address of person/agency sending information)

To disclose to:_____

(Name and address of person/agency receiving the disclosure)

The purpose of this disclosure is _____

Information to Disclose

	Entire Record		Treatment Recommendations/Plan
	Attendance		Treatment Progress Report
	Medication Prescribed		HIV/AIDS Diagnosis/Treatment Information
	Test Results		Discharge Summary
	Diagnosis/Presenting, Problem Information		Information from my Therapy Chart
	Assessment Summary/Evaluation		Other (please specify below):
	Appointments, prescriptions, test results		Billing Information

Time period or other specifics related to the information to be disclosed (if none are specified, all records of the type (s) selected above will be shared):

You are authorizing ROADS Community Care Clinic to disclose your records in the following formats: verbal, written, electronic, unless otherwise specified here:_____

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it before I revoked it. A photocopy of facsimile of this consent is as valid as the original. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. At my request, a copy of this form will be provided to me.

Date or event upon which this consent will expire:_____. I understand if I do not note a date or event, then this consent will expire one year from the last date of service to me at ROADS Community Care Clinic.

Patient Signature	Date
Parent, Guardian, Legal Representative	Date