Patient Name:_____

MRN: _____

GENERAL CONSENT FOR MEDICAL TREATMENT / HEALTHCARE

CONSENT FOR TREATMENT: I hereby **voluntarily consent** to care, treatment, testing, and all other services performed by healthcare providers at Sansum Clinic. I understand that I have the right to refuse to consent to any proposed care, testing, treatment, surgery, or procedure. I also understand that I have the right to ask questions and discuss my concerns with my healthcare provider.

I am aware that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I acknowledge that no guarantees have been made to me as to the outcome of my care, examination, and/or treatment at Sansum Clinic.

I understand that imagery and photography may be used in the course of my visits with my healthcare provider in order to protect and authenticate my medical identity.

I understand that I am required to sign this consent annually or whenever Sansum Clinic deems it necessary. I understand that I may revoke this consent at any time by writing to the Sansum Clinic Health Information Services (HIS) Department, Release of Information, 89 South Patterson Avenue, Santa Barbara, CA 93111. *Attention*: Correspondence, but that my revocation of consent will result in me no longer being able to receive care or treatment from Sansum Clinic.

RELEASE OF MEDICAL INFORMATION: I understand that Sansum Clinic maintains both electronic and paper-based documentation of my medical care and health records and has the duty to protect my information. This documentation typically includes information about my symptoms and health condition; results of physical examinations and diagnostic tests; a plan regarding future care and treatment; as well as demographic and photographic identifiers. Such individually identifiable information about me is protected health information (PHI) and, as such, will be used, shared, or disclosed only for the purpose of treatment, payment, and healthcare operations, or as required by law. Otherwise, my PHI will not be inspected or released without my specific authorization except in certain circumstances, which are outlined in Sansum Clinic's Notice of Privacy Practices.

I understand that the Sansum Clinic Notice of Privacy Practices is publicly posted in English and Spanish in a clear and prominent location in all Sansum Clinic facilities and is available on the Sansum Clinic website. The Notice of Privacy Practices outlines how my PHI may be used and disclosed. The Notice of Privacy Practices also details my rights to access, limit, obtain, and correct my medical and health care information, and my right to make a complaint if I feel my privacy rights have been violated. **I understand that I may request a written copy of the Notice of Privacy Practices at any time and Sansum Clinic staff will provide it to me.**

Additionally, I am aware that data and information concerning essential medical treatment and healthcare services rendered on my behalf may be disclosed, when necessary, to healthcare providers in emergent situations and/or to public and private health insurance plans in order to receive payment as outlined in the Sansum Clinic Financial Policy. **I acknowledge that I am required to sign the Sansum Clinic Financial Policy in order to receive care or treatment from Sansum Clinic**. However, I understand that I may request that PHI associated with that portion of my healthcare at Sansum Clinic for which I have paid out-of-pocket not be disclosed to my health plan or insurance company. I understand further that this request must be made in

writing to Sansum Clinic Health Information Services (HIS) Department, Release of Information, 89 South Patterson Avenue, Santa Barbara, CA 93111.

PATIENT RIGHTS & RESPONSIBILITIES: I acknowledge that my healthcare is a partnership between Sansum Clinic and me, and I agree to actively participate and to accept both my role and responsibilities with regard to my healthcare decisions. I understand that a list of Patient Rights and Responsibilities is posted in English and Spanish in a clear and prominent location in all Sansum Clinic facilities and on the Sansum Clinic website. **I understand that I may request a written copy of the Patient Rights and Responsibilities at any time and Sansum Clinic staff will provide it to me**.

CALIFORNIA IMMUNIZATION REGISTRY (CAIR): Sansum Clinic participates in the California Immunization Registry (CAIR), located at 909 12th Street, #200, Sacramento, CA 95814. I understand that my information or my child's information (including name, date of birth, types and date of immunizations received, manufacturer and lot number for each immunization received, adverse reactions to immunizations received, other nonmedical information necessary to establish identity, results of tuberculosis screening, current address and telephone number, gender, and place of birth) will be included in CAIR unless I choose not to participate. Any of the information shared with CAIR shall be treated as confidential medical information and shall be used to share, upon request, only with health care providers, schools, child care facilities, family child care homes, WIC service providers, county welfare departments, foster care agencies, and health care plans, only for the purposes of providing immunization services, including issuing reminder notifications, for facilitating payment for immunizations, for checking immunization status, and for statistical purposes. I have the right to examine any immunization-related information shared in this manner and to correct any errors in it. If I refuse to allow this information to be shared with CAIR, Sansum Clinic will maintain access to this information for the purposes of patient care or protecting public health. The local health department and the State Department of Public Health will maintain access to this information for the purpose of protecting public health.

ADVANCE DIRECTIVES: I understand that adults 18 years of age and older have the right to either (A) give directions about their future medical care or (B) to designate patient representatives to make medical decisions for them if they lose individual decision-making capacity. **I understand that information about advance directives is available to me upon request**.

ATTESTATION: By signing this form, I agree that I have read and fully understand the content and references contained above in this General Consent form in its entirety. I acknowledge that all of my questions have been answered to my personal satisfaction.

Full Name (Please print):	**Relationship to Patient:**
Signature:	**Date:**

Staff name (Please print):	**Department:**
Staff Signature:	**Date:**

Sansum Clinic does not and shall not discriminate on the basis of race, color, national origin, ancestry, age, sex, sexual orientation, marital status, religion, disability or any other characteristic protected by law. See more at SansumClinic.org.

Effective Date: 10/1/2021