Patient Name:_____

MRN:_____

(Do not affix label, print clearly)

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 do understand that I have the right to refuse to consent to any proposed care, testing, treatment, surgery, or procedure. Moreover, 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. Further, I understand that imagery and photography may be used in the course of my visits with my healthcare provider in order to protect my medical identity.

_____***(Initial)***

I understand that I am required to sign this consent annually or whenever necessary, although I may revoke this consent at any time by writing to Health Information Services (HIS), Release of Information Department (ROI), 89 South Patterson Avenue, Santa Barbara, CA 93111. *Attention:* Correspondence. _____***(Initial)***

RELEASE OF MEDICAL INFORMATION: I understand that both electronic and paper-based documentation of medical care received are maintained. This medical or health record 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, it will not be inspected or released without my specific authorization except in certain circumstances as outlined in the ***Notice of Privacy Practices***. _____***(Initial)***

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 our Financial Policy. However, I may request that PHI associated with that portion of my healthcare at Sansum Clinic for which I paid out-of-pocket in full not be disclosed to my health plan or insurance company. I understand further that this request must be in writing and submitted to Health Information Services.

Note*:** A copy of the Sansum Clinic ***Notice of Privacy Practices is posted in both English and Spanish within the facility, and a paper copy is available at each registration desk.

_____***(Initial)***

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 non-medical 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. You have the right to examine any immunization-related information shared in this manner and to correct any errors in it. If you 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.

PATIENT RIGHTS & RESPONSIBILITIES: I acknowledge that my healthcare is a partnership between Sansum Clinic and me; hence, I agree to actively participate and to accept both my role and responsibility with regard to my healthcare and the rights available to me. A list of patient rights and responsibilities is posted in both Spanish and English within the facility. A copy of this list is available to me upon request. _____ ***(Initial)***

ADVANCE DIRECTIVES: Adults 18 years and older have the right either (a) to 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. _____ ***(Initial)***

ATTESTATION: I have read and now fully understand the content and references contained in this consent form in its entirety, and all of my questions have been answered to my personal satisfaction.

Patient Name: _____ Date: _____
(***Sign***)

Patient Representative: _____ Date: _____
(Print) / ***(Sign)***

Sansum Clinic Representative Initials: _____ Date: _____