sansum CLINIC

Patient Name: _____
MRN: _____
(Do not affix label, print clearly)

Record Base #: _____

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. At the same time, I do understand that I have the right to refuse consent to any proposed care, treatment, testing, 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. I understand 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.

While I understand that I am required to sign this consent annually or as necessary, I may revoke this consent at any time by writing to the Sansum Clinic Health Information Services (HIS) Department, Release of Information Office, 317 West Pueblo Street, Santa Barbara, California 93105, *Attention:* Correspondence. _____ ***(Initial)***

RELEASE OF MEDICAL INFORMATION: I understand that Sansum Clinic shall maintain both electronic and paper-based documentation of the medical care received. This medical record will typically include individually identifiable 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 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. Otherwise, it will not be inspected or released without my specific authorization except in certain circumstances 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 released, 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. However, I may request that PHI associated with that portion of my healthcare at Sansum Clinic, for which I paid out-of-pocket, not be disclosed to my health plan or insurance company. I understand that this request must be in writing.

A copy of the **Notice of Privacy Practices** is posted openly in both English and Spanish within the facility, and a paper copy is available at each registration desk. _____***(Initial)***

PATIENT RIGHTS & RESPONSIBILITIES: I acknowledge that my healthcare is a partnership between Sansum Clinic and me; hence, I agree to actively participate and accept both my role and responsibility in reference 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 upon request. _____ ***(Initial)***

ADVANCE DIRECTIVES: Adults 18 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 of this consent form in its entirety, and all of my questions have been answered to my satisfaction.

Patient Name:_____ Date: _____
(sign)

Patient Representative:_____ Date: _____
(print & sign)

Clinic Representative Initials:_____ Date: _____