PATIENT CONSENT TO MEDICAL CARE &
DISCLOSURE OF PATIENT MEDICAL INFORMATION

I, the undersigned, hereby consent, for myself or the patient listed whom I am legally responsible for, to the following treatment:

- Administration & performance of all treatments
- Use of prescribed medications
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Administration of any needed anesthetics
- Performance of diagnostic procedures, tests and cultures
- Performance of other medically acceptable laboratory tests that may be considered medically necessary or advisable based on the judgement of the attending medical provider

I fully understand that this consent is given in advance of any specific diagnosis or treatment and intend for this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I, the undersigned, acknowledge that Tri State Community Clinics, LLC will use and disclose my information for the purposes of treatment and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature Date

AUTHORIZATION TO LEAVE PERSONAL
HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name:_____ **DOB:**_____

From time to time it may be necessary for representative of Tri State Community Clinics to contact patients for various notification purposes that could include *Protected Health Information* such as, but not limited to:

- Appointment reminders/confirmation/rescheduling
- Lab test results
- Prescription renewal/reminder information
- Requests to call us for other issues

We would like to know how we can contact you and with whom we can leave a message or share other information about your *Protected Health Information*. I authorize Tri State Community Clinics providers and/or staff to contact me and leave detailed messages that could include *Protected Health Information* pertaining to my care by the methods selected below:

Check and complete all that apply:

	Method	
❑	Cell phone/voice message	Number with Area Code: ( )
❑	Campus email	Email Address:

AUTHORIZATION TO SHARE PERSONAL HEALTH
INFORMATION WITH CERTAIN INDIVIDUALS

In addition, I give permission for the following individuals to receive my Protected Health Information:

Name	**Relationship**	**Number w/ Area Code**
		( )
		( )

❑	I authorize Tri State Community Clinics, LLC to release my pertinent medical information, when necessary, to the appropriate University of Evansville officials. (i.e. exposure to communicable disease, safety of myself and others, as required by law)

With my signature below, I acknowledge and understand that this Authorization will be kept as part of the medical record, for me or the patient listed whom I am legally responsible for, and that the communication instructions listed above will remain in effect until revoked or changed by me in writing.

_____ _____

Patient (or Responsible Party) Signature Date