

**Treatment and Medication History Consent and
Patient Acknowledgment of the Notice of Privacy Practices and
Consent to Use and Disclose Health Information**



I consent to all necessary steps taken for examination, diagnosis and treatment. If at any time I have questions about my examination, diagnosis, or treatment, I will not proceed until my questions have been answered so that I am fully informed. I understand that giving the providers and nurses all relevant information is important to my proper diagnosis and treatment. I understand complete compliance with my provider's instructions is critical to the success of any treatment prescribed.

If required by law, I acknowledge that I was provided with an opportunity of a copy of the One to One Health Notice of Privacy Practices regarding uses and disclosures of information regarding me and my health ("Health Information"). I hereby consent to the use and disclosure of my health information, for the purposes and activities permitted under the federal privacy and state privacy laws, which are described in the One to One Health Notice of Privacy Practices.

I specifically authorize the release, to the fullest extent permitted by law, for treatment, payment or operations purposes as described in the Notice of Privacy Practices, of information regarding the results of any HIV/AIDS testing or treatment, mental health treatment and substance abuse treatment.

I authorize One to One Health to release my health information to my health plan or to a health and wellness provider approved by my health plan for purposes of advising me concerning appropriate measures to maintain or improve my health or any condition reflected in my records.

I authorize One to One Health to release information to my designated insurance plan for the purpose of health plan administration, including receiving or making payment for services rendered on my behalf. I understand a patient is responsible for all charges incurred, subject to contract and program rules, regardless of my insurance status. If it becomes necessary to send this account to collections, the patient will be responsible for all additional charges.

I have read and do understand the above information.

Patient/Personal Representative Signature

Date

Patient/Participant Name (please print)

Date of Birth

Relationship of Personal Representative (parent/legal guardian): _____

For Site Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Patient did not sign or refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please describe: _____)