University of Connecticut
Health Center
John Dempsey Hospital and
UCONN Medical Group

(Patient Identification)

Permission to Treat

CONSENT TO BASIC TREATMENT AND DIAGNOSTIC PROCEDURES: This is to certify that I, the undersigned, consent to the administration of treatment to the above named patient at the University of Connecticut Health Center (UCHC) which includes: UConn Medical Group (aka University Physicians)/ University Dentists, John Dempsey Hospital, the School of Dental Medicine, or any provider under contract with them. I consent to any x-ray, laboratory (including voluntary testing for HIV), or other medical/dental procedures of examination and any other service rendered to me under the general and specific instruction of my physician/dentist. I understand that, except in emergency, all special procedures, blood or plasma transfusions, use of anesthetics or conscious sedation, will be discussed with me by my physician/dentist and that an additional specific consent form may be required. Unless revoked in writing, this permission will be good for six months.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I consent to allow the UCHC as defined above, to use and disclose my protected health information (PHI) within UCHC, to carry out my treatment, to obtain payment and to carry out health care operations. My PHI may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services, and process medical/dental claims. My PHI may be disclosed to outside health agencies or institutions involved in my continuing care when I am transferred to another facility and/or for emergency care purposes. My physician may also share my PHI with referring physicians for continuing care as deemed appropriate by me. My PHI may include medical/dental information or any information pertaining to the examination, treatment, history, which may include Psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical/dental information and charges to my health plan and/or their acting intermediaries and/or agents. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it; withdrawal of consent shall be addressed in writing to the Director of Medical Records.

ASSIGNMENT OF BENEFITS: I authorize my health plan to pay benefits directly to UCHC, or any provider under contract with them. I understand that in the event my health plan or healthcare contract does not cover services, I will be responsible for payment. Examples include co-payments, deductibles, charges considered to be beyond usual, customary, and reasonable or uncovered services (such as cosmetic surgery).

NON-ASSIGNMENT OF BENEFITS OR SELF-PAY: I understand that if my health plan does not consider UCHC, or any other provider under contract with them, a participating provider, charges incurred will be paid by me. I further agree to accept full financial responsibility for payment of charges rendered to the above patient.

ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES: I understand that specific information regarding the uses and disclosures of my PHI can be found in the UCHC Notice of Privacy Practices which has been provided to me and which I have a right to review before I sign this. I further understand that the UCHC has a right to change its Notice of Privacy Practices and that I may obtain a revised copy on UCHC's web site http://health.uchc.edu or the Patient Relations Office. I understand that I have the right to request that UCHC restrict how my PHI is used and disclosed for treatment, payment and health care operations. I further understand that UCHC is not required to agree to my requested restrictions. However, if UCHC agrees to a requested restriction, it is bound by it.

Patient has: ☐ **refused to acknowledge written receipt of Notice of Privacy Practices:**
☐ **unable to acknowledge written receipt of the Notice of Privacy Practices, though good faith efforts have been made:**

Explain: ____

I have read and agree to all parts of this form unless I have noted so directly on the form above.

______________________	________	______________________
Signature of Patient or Legal Representative	**Date / Time**	**(Relationship to patient)**
______________________	________	______________________
All above Signatures Witnessed by:	**Date / Time**	**Title**

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