Consent for Treatment

COLUMBIA GORGE
FAMILY MEDICINE

1750 12th Street
Hood River, OR 97031

Phone: 541-386-5070
Fax: 541-386-7190
Web: www.cgfm.com

Date: _____ **Birthdate:** _____
(mm/dd/yyyy) (mm/dd/yyyy)

Patient Name: _____
(last name, first name, middle initial)

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physicians. This consent is valid until such time it is revoked in writing or a new consent is completed.

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Columbia Gorge Family Medicine to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices is available at the front desk and also our website, www.cgfm.com. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 541-386-5070. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request and we are bound by this agreement.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

ASSIGNMENT OF BENEFITS:

I hereby authorize my insurance benefits be paid directly to Columbia Gorge Family Medicine. I understand I am financially responsible for non-covered services, any remaining deductible and co-pay. I also authorize Columbia Gorge Family Medicine to release any information required in the processing of this claim.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent. The date effective of a written revoked consent will be the date it is received and scanned into the patients chart.

PRESCRIPTION DATA:

I authorize Columbia Gorge Family Medicine to obtain information regarding my prescriptions from pharmacies and other outside sources to better coordinate my healthcare. ☐ Yes ☐ No

REVOCATION RIGHTS:

I hereby consent to the authorizations described above and will accept medical treatment from Columbia Gorge Family Medicine. This authorization will stay in effect until such time a new one is signed or a written revocation is done.

Signed _____ **by** _____
(mm/dd/yyyy) Signature of patient

Signed _____ **by** _____
(mm/dd/yyyy) Signature of parent, guardian, or legal representative

Any person listed below has my permission to authorize medical treatment for me/this patient. These same people have the right to discuss my health care with representatives of the practice for purposes of treatment, billing, or health care operations.

1) Name: _____
Please PRINT name and relationship to patient Phone Number

2) Name: _____
Please PRINT name and relationship to patient Phone Number

3) Name: _____
Please PRINT name and relationship to patient Phone Number