CP Rochester

Opening Doors...Changing Lives

Name of Consumer: _____ **DOB**_____

I. HIPAA Privacy Rule

☐ I hereby acknowledge that I am aware of the HIPAA Privacy Rule and have been offered a copy of CP Rochester's Notice of Privacy Practice.

II. Consent for Treatment and/or Services

☐ I hereby authorize examinations, evaluations, tests, treatments and services to be provided as necessary. In signing this consent, I understand that my protected health information may be used for the purposes of treatment, payment, and operations.

III. Consent to Release Information

☐ I hereby request and give consent to CP Rochester to release my health information to the following additional individual(s), group(s), or organization(s):

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone(s):_____ Phone(s):_____

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone(s):_____ Phone(s):_____

Please list additional individuals, groups, or organizations on the reverse side of this form.

Signed: _____ **Date:** _____

Print Name: _____

If person completing this form is other than the consumer, please check the relationship:

_____ parent or guardian of minor consumer _____beneficiary or personal representative

_____ guardian/conservator of an incompetent consumer _____ other: _____