CONSENT FOR TREATMENT, RIGHT TO AUTHORIZE AND/OR RESTRICT RELEASE OF PROTECTED HEALTH INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS, ETC.

FORM #1170

KNOWLEDGE OF RIGHT TO AUTHORIZE AND/OR RESTRICT THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) TO THIRD PARTIES: I understand I have the right to authorize and/or restrict the release of my protected health information (PHI) to certain third parties.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize MSDH to seek reimbursement from my insurance provider or guarantor. Charges for services rendered which are not reimbursed by my insurance provider or guarantor are the responsibility of the patient.

MEDICAID PATIENT CERTIFICATION: If applicable, I certify that I am a recipient of the Medicaid Title XIX program and request that payment of authorized benefits be made on my behalf. I authorize any holder of medical or other information about me (including PHI) to make available to the Division of Medicaid any requested information (including PHI) concerning medical, insurance, and financial records related to any services provided to me. I assign the Medicaid benefits payable for services provided to me to MSDH for furnishing such services.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT: If applicable, I certify that the Information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me (including PHI) to release to the Social Security Administration or its intermediaries or carriers any information (including PHI) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services rendered to MSDH.

COMMUNICATION AUTHORIZATION: I agree that MSDH and all of its related entities, agents, servicers, independent contractors, assigns, and successors may call, message, text, or otherwise contact me (hereinafter "communication"), including through the use of dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice message, even if I am charged by my telecommunication provider or other party for the communication. I expressly agree that such communication may be made by MSDH to any telephone number (including numbers assigned to any paging, cellular, or mobile service, or any service for which I am charged for the communication) I have provided previously or may provide in the future in connection with my account. I expressly consent to receiving any such communication. With such consent, I specifically waive any claim I may have against MSDH for making such communications to me, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C §7.

CONSENT FOR TREATMENT: The undersigned authorizes MSDH to furnish medical and surgical treatment deemed appropriate including, but not limited to, local, general, and regional

anesthetics, antibiotics or other drugs deemed necessary. I am aware that adverse unforeseen reactions can occur and may even result in death. I authorize MSDH to take photographs, video, audio, or other images or recordings of me or parts of my body while under the care of MSDH for use in medical evaluation.

TISSUE, BLOOD, AND SALIVA SAMPLES AUTHORIZATION: In regards to tissue, blood, saliva, parts and the like taken during my care, I hereby authorize MSDH to preserve, use, disclose or share these for scientific or teaching purposes, including research, and/or health care operations.

PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge I have been informed of the Patient Rights and Responsibilities and understand that a printed copy is available to me at my request.

RETIREMENT/DESTRUCTION OF IMAGES: I hereby authorize MSDH to retire radiographic images (such as X-rays) and any other graphic data which may be generated during my care four (4) years after they are generated, if a report of the findings (signed by the professional who read and interpreted the images or other graphic data) is retained for the same period as other medical records. Further, I hereby release and hold harmless MSDH, its officers, staff and employees, from any liability connected with this process.

VOLUNTARY PARTICIPATION AND CONFIDENTIALITY STATEMENT: Title X services are provided solely on a voluntary basis. I understand that I am not required to receive services or to use or not use any particular method of Family Planning. Acceptance of Family Planning services is not a prerequisite to eligibility for, or receipt of, any other service or assistance from or participation in any other MSDH programs. This information is confidential and will be treated as such.

Si necesita esta información en español, consulte a su proveedor de MSDH o llame 1-866-458-4948 o comuníquese con su oficina local de MSDH. Información de contacto de las oficinas esta localizado en el sitio web de MSDH http://www.msdh.ms.gov.

_____	_____
Print Name of Patient, Guardian or Representative	Print Name of Insured
_____	_____
Signature of Patient, Guardian or Representative	Signature of Insured
_____	_____
Description of Representative	Date

_____
Date

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PURPOSE

To obtain patient consent for treatment.

To obtain patient authorization to: communicate with the patient; release PHI to insurance benefits programs as needed to process a claim; share tissue, blood, and saliva samples for research; seek reimbursement from insurance provider or guarantor; and destroy radiographic images.

To provide patient knowledge of their right to authorize and/or restrict access to PHI.

To provide notice of Patient Rights and Responsibilities.

To provide notice to Title X Family Planning patients regarding voluntary participation and confidentiality.

INSTRUCTIONS

Review with patient and obtain signature(s) prior to provision of services.

If the representative/guardian of the patient must sign, he or she must indicate their relationship to the patient and provide any required supporting documentation to prove their capacity to sign.

OFFICE MECHANICS AND FILING

Becomes a part of the patient's medical record and is to be completed at each visit.

RETENTION

The form will be scanned into the patient's electronic record and verified for clarity and orientation.