Dental HIPAA Authorization

Name: (Last)_____ (First)_____ (MI) ____ Date of Birth:_____

Printed Name of Parent or Legal Guardian (If applicable): _____

Health Insurance Portability and Accountability Act (HIPAA) Authorization

I authorize **Center Street Community Health Center and Morrow Family Health Center** to use and disclose my following **Protected Health Information (PHI)** listed below for the purposes listed elsewhere on the page.

List individuals you would allow us to share medical information with if necessary.

Name of entity or person(s) to receive information:

Upon supplying proof of identity by showing acceptable form of photo identification, the above listed person(s) may have access to my: medications, prescriptions, documentation in sealed envelope, appointment time, and any life-threatening, emergency information.

This Protected Health Information (PHI) is being given or disclosed for the following purpose(s): Continuity of Care

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at Center Street Community Health Center Corporate office. I understand that revocation is not effective to the extent that my provider has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect remuneration to the provider from a third party.

If the disclosure concerns a patient in an alcohol or drug abuse program, the following notice shall accompany the disclosure: This information has been disclosed to you from our records protected by federal confidentiality rules (442CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I SPECIFICALLY AUTHORIZE THE DISCLOSURE TO & RELEASE FROM ABOVE NOTED AGENCIES REGARDING THE INFORMATION BELOW:

___ Mental Health Information- current diagnosis & medication list
___ Substance abuse (including alcohol/drug abuse)
___ STD related information (STD testing)
___ HIV related information (AIDS related testing)

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you do not agree with these terms, we will be unable to serve as your provider.

Dental E-Prescribing Consent

Name: (Last)_____ (First)_____ (MI) _____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

E-Prescribing/Pharmacy Benefit Management (PBM) Consent

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations know as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an E-Prescribe program.

These include:

*Formulary and benefits transactions: Gives the prescriber information about which drugs are covered by the drug benefit plan.

*Medication History Transactions: Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you do not agree with these terms, we will be unable to serve as your provider.

Dental Treatment Consent

Name: (Last)_____ (First)_____ (MI) _____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

Treatment Consent

I understand that treatment provided to me by any medical, dental, nursing students, LISW, or PsyD staff will be properly supervised by a licensed practitioner. I am giving permission for any exams, tests, or other services that the provider believes are needed. Center Street Community Health Center and Morrow Family Health Center makes sure that all staff who need licensed by the State of Ohio have the proper credentials. I understand and agree that I will participate in the planning of my care, treatment, and/or services. I understand that I may stop care, treatment, and/or services at any time. I also understand that there are no guarantees that treatment will be successful.

CSCHC and MFHC have right to treat me without consent only in three situation:

1) Emergencies 2) When non-verbal communications show implied consent 3) When legally bound to treat.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you do not agree with these terms, we will be unable to serve as your provider.