MOUNTAIN COMPREHENSIVE CARE CENTER, INC.
Consent for Uses and Disclosures to Carry Out Treatment, Payment and Health Care Operations

Client Name _____ **Social Security Number** _____

We may use and disclose protected health information about you to carry out **treatment, payment and health care operations.** You have the right to review the Notice of Privacy Practices before signing this consent.

You have received a copy of our current Notice of Privacy Practices. It contains a more complete description of the uses and disclosures we may make. It also explains your rights and our duties with respect to protected health information. The terms of our Notice of Privacy Practices may change. At any time, you can obtain a revised, up-to-date copy of the Notice by contacting any MCCC site or by accessing our webpage at www.mtcomp.org.

You have the right to ask that we restrict how protected health information about you is used or disclosed to carry out treatment, payment or health care operations. We are not required to agree to any restriction you request. If we do agree to a restriction, however, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent that we have taken action in reliance on your consent.
By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment and health care operations.

INITIAL ONLY ONE: (You will be treated without restrictions, if neither blank below is initialed)

_____ **(With Restrictions)** I also confirm that any restrictions I desire are stated on reverse side of this form.

OR

_✓_ **(Without Restrictions)** I also confirm that I have not requested any restriction on your use or disclosure of protected health information for any of those purposed.

TB Referral: As part of your treatment, we encourage you to obtain a TB Skin Test. Early detection can be very beneficial and treatment very successful. Contact your local healthcare provider for more information

Service Agreement: Service Fees have been explained to me. The initial record setup fee is $10. Payment is required on date of service. I understand that I am ultimately responsible for payment of services as set forth on the Service Fee Agreement. I understand that I may not be allowed to return for services at MCCC until any past due account balances have been paid in full.

Voter Registration Information: As a result of the National Voter Registration Act, we are required to ask if you would like to register to vote.

- ☐ N/A - Client is child
- ☐ Yes I hereby acknowledge I have been given a voter registration form and was provided assistance
- ☐ No I am a registered voter **or** I am not interested in registering to vote at this time.

_____ _____
Client Signature Date

_____ Basis for Authority to Sign:
Personal Representative (If applicable)* ☐ Parent ☐ Guardian ☐ Other_____

_____ _____
Witness Date

*By signature, I am representing that I have legal authorization to consent for treatment for the client named above. (Documentation may be required)

DESIRED RESTRICTIONS

I hereby request that the following restrictions be placed on uses and disclosures to carry out treatment, payment and health care operations:

_____

_____

_____

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_____

_____ _____

Client Signature Date

_____ _____

Personal Representative (If applicable) Date

MCCC hereby agrees with the following requested restrictions:

_____

_____

_____

_____

MCCC Staff

_____

Date