LUCAS COUNTY HEALTH CENTER

An Affiliate of UnityPoint Health

CHARITON CLINIC

Confidentiality and Consent Form

Patient Name: (print) _____ Date of Birth: _____

By completing the consent below, I hereby authorize Lucas County Health Center's Chariton Clinic (LCHC's Chariton Clinic) to discuss my billing and/or medical records with the person(s) listed below. Unless notified in writing, this consent will remain in effect permanently.

I give consent to my provider and/or staff at LCHC's Chariton Clinic to discuss my billing, chart and/or medical records with the following persons:

Name: _____ Phone #: _____ Relationship: _____
Name: _____ Phone #: _____ Relationship: _____
Name: _____ Phone #: _____ Relationship: _____
Name: _____ Phone #: _____ Relationship: _____

By completing the consent below, I hereby authorize LCHC's Chariton Clinic to call and leave their name, provider's name and additional information on an answering machine or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I give my consent to my provider and or staff at LCHC's Chariton Clinic to leave a message regarding treatment, test results, or other information as necessary.

_____ on my answering machine at home phone #: _____
_____ on voicemail at work phone #: _____
_____ with a specific individual

I request that payment under the medical insurance program be made either to me or to LCHC's Chariton Clinic on any bills for services furnished to me during the effective period of this authorization and I authorize LCHC's Chariton Clinic to release to the Social Security Administration or its intermediaries or carries any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Medicare Number: _____

Signature: _____ Date: _____
(Patient or Authorized Guardian)