

COMMUNITY CLINIC, INC.

200 Girard Street, #212 Gaithersburg, MD 20877 301-216-0880	9001 Edmonston Road, #40 Greenbelt, MD 20770 240-790-3327	8210 Colonial Lane Silver Spring, MD 20910 301-585-1250	7676 New Hampshire Ave. #220 Takoma Park, MD 20912 301-431-2972
---	---	---	--

Consent For Use/Disclosure

Patient's Name: _____ Chart # _____

Date of Birth: _____

I understand that the patient's health information is private and confidential. I understand that CCI (Community Clinic Inc.) works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. I understand that CCI may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. CCI has a detailed document called the Notice of Privacy Practices. It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the Notice before signing this agreement.

CCI may update this Notice of Privacy Practices". If asked, CCI will provide me with the most current Notice of Privacy Practices.

Under the terms of this consent, I can ask CCI to limit how the patient's personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that CCI does not have to agree to my request. If CCI does agree to my request, I understand that CCI would follow the agreed limits.

I may cancel this consent in writing at any time by:

Writing, signing, and dating a letter to CCI. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

If I revoke this consent, CCI does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of CCI's Notice of Privacy Practices.

My signature means that I agree to allow CCI to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

Patient or legally authorized individual's signature

Date

Relationship to patient if signed by anyone other than the patient.
(Parent, legal guardian, personal representative, etc.)

CCI Staff Signature

Community Clinic, Inc.

Mission

Community Clinic, Inc. provides high quality primary care and health-related services for medically- underserved persons, promotes improved access to health care services, and conducts its mission in a non-discriminatory manner, sensitive to the needs of the community and the dignity of every individual.