Health Care for the Homeless
2222 Simon Bolivar Ave. **1530 Gravier Street**
N. O., LA. 70113 **N. O., LA. 70112**

CONSENT FORM

Please Review Carefully

Patient's Name: _____ Date of Birth: _____

CONSENT FOR TREATMENT: I agree to become a patient of the Health Care for the Homeless (HCH) clinics and I consent to medical and dental treatment, as well as diagnostic testing deemed necessary by the judgement of the physician, nurse practitioner, or dentist assigned to me.
I AM AWARE THAT THE PRACTICE OF MEDICINE AND DENTISTRY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS THE RESULTS OF EXAMINATION OR TREATMENT.

Patient's Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS: I authorize direct payment to HCH, of all medical benefits, settlements, or judgments applicable to my treatment by HCH providers and clinicians at their clinics. This authorization is applicable to all future charges and fees from, and including, this day forward, unless revoked by me in writing.
THE UNDERSIGNED CERTIFICATES THAT I HAS READ THE FOREGOING, AS THE PATIENT; I DULY AUTHORIZED HCH TO EXECUTE THE ABOVE AND ACCEPT THE TERMS AND CONITIONS.

Patient Signature: _____ Date: _____

RELEASE OF INFORMATION: I authorize HCH and/or its providers and clinicians to disclose all or part of my medical and/or billing records to any insurance carrier or persons employed by the insurance carrier for the purpose of collecting insurance benefits and auditing claims, so long as I am listed on the account as having coverage with the insurance carrier. This authorization includes release of information to group health plans applicable to my treatment. I hereby indemnify and release HCH and its providers and clinicians from any and all responsibility relative to the release of such information.

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES: The Notice of Privacy Practices tells you how the Health Care for the Homeless (HCH) Clinics uses and discloses your information. Not all situations will be described. We are required to give you a notice of our privacy practices for the information we collect and keep about you.

I, _____, have been given a copy of the HCH'S Privacy Practices and have had a chance to ask questions about how my information will be used and disclosed.

Patient Signature: _____ Date: _____

Authorized Representative: _____ Date: _____

GREATER NEW ORLEANS HEALTH INFORMATION EXCHANGE (GNOHIE) PATIENT OPT OUT CONSENT POLICY: HCH uses the GNOHIE to store patients' health care information. The GNOHIE provides an easy method that allows your health information to be shared electronically with HCH and other GNOHIE partners, which include your doctors, nurses, and other care providers. This helps your doctors, nurses, and other care providers to work together to provide you care. You can elect not to have your medical records shared through GNOHIE by calling the GNOHIE Service Desk at 1-855-446-6443 (1-855-4GNOHIE) or by submitting an electronic request through the GNOHIE Consent Website, www.gnohie.org. Click on "FAQs" to learn more. If you are under 18 or have a legal guardian, your parent or guardian must opt out for you.