

AUTHORIZATION FOR TREATMENT: I understand that I have a health concern which requires diagnosis and treatment, and I authorize Hudson Physicians to provide such diagnosis and treatment. I understand that diagnostic procedures and medical care ordered by my physician are in his/her opinion necessary to treat my health concerns.

PAYMENT AUTHORIZATION: I request that payment be made on my behalf to Hudson Physicians for services furnished to me by Hudson Physicians. I authorize Hudson Physicians to release to the Centers for Medicare & Medicaid Services and its agents, any state Medicaid agency, and any other third party payor all medical or other information that is needed to determine the benefits payable for health services. I agree to pay the charges for the care and treatment rendered to me that is not covered by insurance.

RECORD RELEASE: I hereby authorize the release of my medical information (including information, if any, about substance abuse, mental health and HIV/AIDS) to my referring provider and any health care provider currently involved in my treatment.

Patient's Printed Name: _____

_____ Date _____ Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor

*If signed by patient representative or parent/legal guardian, indicate relationship to patient:

AUTHORIZATION FOR DATA SHARING ARRANGEMENT: I understand and agree that my insurance company may share my past, current and future health and account records with Hudson Physicians about services I've received from Hudson Physicians and other care providers unrelated to Hudson Physicians. These records may be used by Hudson Physicians as needed to manage or coordinate my care and to improve the quality of care. If I do not agree to this, I will initial below.

_____ My insurance company may not release any identifiable health records from providers unrelated to Hudson Physicians for the purposes described above.

MEDICAL HOME AUTHORIZATION: Hudson Physicians is a medical home facility. A medical home facilitates partnership between patients, their providers, and the rest of their designated health care team. It provides comprehensive primary care for all patients and allows better access to health care, increased satisfaction, and improved overall health. Patients may change their medical home status at any time.

I choose Hudson Physicians as my primary medical home clinic. Yes No

CONSENT FOR TREATMENT OF MINORS: Hudson Physicians requires that a parent or legal guardian accompany any minor children (17 years old or younger) to their medical appointments. In the event that a parent or legal guardian is unable to accompany a minor child to a medical appointment, the parent or legal guardian must sign this Consent for Treatment of Minors to be kept on file at Hudson Physicians Clinic. I authorize care and treatment for my unaccompanied child referenced as *Patient's Printed Name* above. I agree to reimburse Hudson Physicians for the services rendered to my child in my absence. The following individuals may authorize treatment for my child:

Name:	Relationship to Minor Child
_____	_____
_____	_____
_____	_____

Authorized Consent Required Signature updated annually