Hopelight Medical Clinic

Consent for Treatment

I, the undersigned, hereby give consent to the provision of care, diagnosis and/or treatment by Hopelight Medical Clinic (HMC) and the Longmont Community Health Network (LCHN). I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing. I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the care, diagnosis and/or treatment and am not subject to duress or under undue influence. I understand that this authorization applies to all routine health maintenance services and to all services available for acute and chronic medical and behavioral conditions. Furthermore, I acknowledge that no guarantees have been made to me as a result of treatment through HMC.

The services authorized by this consent include those provided under the auspices of HMC by, but not limited to: Medical Staff including physicians, nurse practitioners, physician assistants, nurses, health educators, medical technologists, and medical assistants, and Behavioral Health Staff including behavior analysts and counselors. I further consent to treatment by health professionals-in-training, which are under the supervision of responsible health professionals of HMC.

I understand that HMC will keep my protected health information confidential as directed by law. However, I understand that HMC providers may be required to report to authorities if they have reasonable cause to believe that child abuse or neglect has occurred or is occurring, or if they believe, in good faith, that disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of me or another person. I understand that HMC has contracts and agreements with the State of Colorado which allows for certain sharing of clinical and financial information. These programs include, but are not limited to, the Colorado Indigent Care Program and the State Infectious Disease Control Program. This form only needs to be completed once for the entire household.

Name	Relationship to Signer	Birth Date

Signature of Patient or Person Authorized to Consent Date