Camino Health Center
Affiliated with Mission Hospital

Medical Consent for Treatment Form

Patient Information

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Consent for Treatment: I, the undersigned, authorize and consent to the examination, diagnosis, and treatment provided by Camino Health Center. I understand that this may include medical procedures, diagnostic tests, and other necessary interventions as deemed appropriate by the healthcare provider.

Release of Information: I authorize Camino Health Center to release relevant medical information to insurance providers, referring physicians, and other healthcare professionals involved in my treatment as required by law.

Financial Responsibility: I understand that I may be financially responsible for any services provided that are not covered by my insurance. I agree to pay, based on Camino Health Center's Sliding Fee Discount Program (SFDP), any out-of-pocket expenses incurred during my treatment.

Acknowledgment of Privacy Practices: I acknowledge that I have received or been offered a copy of Camino Health Center's Notice of Privacy Practices, which outlines how my medical information may be used and disclosed.

Consent for Minors (if applicable): If the patient is a minor, I, as the parent or legal guardian, give my consent for the treatment of the minor patient named above.

Right to Refuse or Withdraw Consent: I understand that I have the right to refuse treatment or withdraw consent at any time by notifying Camino Health Center in writing.

Signature & Date: Patient (or Parent/Guardian)

Name: _____ Date: _____

Signature: _____

CHC Staff or Witness Name: _____ Date: _____

Signature of CHC Staff or Witness: _____