# Old Dominion University Community Care Adult-Consent Form

Patient Name SSN # (Last) (First) (MI)

Address

(City/State) (Zip Code)

Home Phone Phone Work # Cell # Email

Date of Birth Sex: M F Other/Decline Race Primary Language

Emergency Contact Ph# Relationship

Primary Care Doctor Ph #

Do you have health insurance? YES \_\_\_\_ NO \_\_\_\_\_

If YES, please check which insurance: Private \_\_\_\_\_ Medicaid \_\_\_\_\_ Medicare \_\_\_\_\_ Tricare \_\_\_\_\_

**By my initial and signature below, I hereby request and authorize the ODU Community Care to:**

**\_\_\_\_\_\_ Consent to Obtain and/or Disclose Records:**

I consent to allow ODU Community Care to obtain and/or disclose records to my Primary Care Physician, Specialists, or healthcare organizations that are involved in my treatment/care.

1. **Use the Electronic Health Record (EHR) to share and receive my medical records with providers from connected care locations**
2. **Use the EHR to download medication history automatically from pharmacy benefit managers**
3. **Release information related to healthcare services provided to the patient to the appropriate third-party payor for payment purposes**
4. **Consent to the viewing, handling, and treatment of mental health and substance use disorder medical records**

Print **Patient’s** name: (Last) (First) (MI) (Date of Birth)

**By my initials and signature below, I hereby request and authorize that I may:**

**\_\_\_\_\_\_ Consent to Treatment:**

 The purpose of this consent is to obtain permission for the provision of healthcare services, including evaluation and treatment by a licensed healthcare provider who may be overseeing a healthcare student(s) or healthcare volunteer.

1. **Receive health care services available from, and deemed necessary by, ODU Community Care,**
2. **Receive referral care and emergency transportation to other health care providers, as deemed necessary by the ODU Community Care.**
3. **I have received or been offered a copy of the “Notice of Privacy Practices” from ODU Community Care.**
4. **Consent for HIV, Hepatitis B and C Testing when a healthcare worker is exposed to the bodily fluids of another person, the patient shall be deemed to have consented to testing and to the release of their results to the exposed person and the local health department under VA code: 32.1-45.1(A)**

**By my initials and signature below, I hereby request and authorize that I may:**

**\_\_\_\_\_\_ Consent for behavioral, mental health (including psychotropic medications), and substance use disorder services:**

Behavioral, mental health, and substance use disorders involve sensitive information. This information is vital to the treatment and care of individuals with these disorders. Psychotropic drugs are medications which effect the mind, emotions, and/or behaviors that can alter brain chemistry, impact body functions, and modify thoughts, moods, feelings, awareness, and perceptions. These medications include antidepressants, anti-anxiety, stimulants, antipsychotics, and mood stabilizers. Your agreement to this treatment is voluntary, and you have the right to ask questions, seek clarification, or withdrawal consent at any time.

**\_\_\_\_\_\_ Consent for Telehealth Services:**

Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care providers and/or specialist. The information may be used for diagnosis, treatment, therapy, follow-up, and education. It may include sharing of the patient medical record, medical images, live two-way audio and video and output data from medical devices that include sound and video files.

# Patient Name (Printed)

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Last Updated 12.10.2024