Patient Name: ______________________________ Date of Birth: _______________

**CONSENT TO TREAT**

I hereby authorize employees and agents, including physicians, physician assistants and nurse practitioners, of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates and assistants of the physician's choice.

______________________________________ ____________________
Signature Date
Relationship if not Patient: ☐ Parent ☐ Legal Guardian

**HIPAA Notice of Privacy Practices and Patient Rights**

Your signature below is acknowledgement of being offered a copy of Chestnut Health Systems' Notice of Privacy Practices and Patient Rights. The Notice of Privacy Practices is available to you at any time from staff or accessible on our website.

The HIPAA Privacy Act allows disclosure of your information for treatment, payment and health care operations without authorization from you. However, you can request restrictions to this disclosure, subject to agreement by Chestnut. These restrictions will be effective until revoked by you in writing unless disclosure has been made. **Please mark:______ No Restrictions ______ Restrictions**

Please list restrictions: ____________________________________________________

**Permission to discuss your health care issues with others**
(We will have you sign a disclosure authorization to disclose mental health and/or substance use disorder information before it is shared.)

Please list the names those people you allow us to share your medical information with:

| Name | Relationship | Phone # | Emergency Contact? |
|---|---|---|---|
| | | | ☐ |
| | | | |
| | | | |

| May we call | Yes | No |
|---|---|---|
| Your home phone | | |
| Your cell phone | | |
| Your work phone | | |

| May we leave a message | Yes | No |
|---|---|---|
| On home phone | | |
| On cell phone | | |
| At work phone | | |

______________________________________ ____________________
Signature Date

Relationship if not Patient: ☐ Parent ☐ Legal Guardian

Chestnut Family Health Centers

702 West Chestnut Street
Bloomington, Illinois 61701
p: 309.557.1400 • f: 309.557.1461
www.chestnut.org

50 Northgate Industrial Drive
Granite City, Illinois 62040
p: 618.512.1919 • f: 618.512.1920
www.chestnut.org