995 Worthington Street, Springfield, MA 01109
Telephone 413-734-5376
FAX 413-737-7949

ROUTINE AND PREVENTIVE MEDICAL CARE CONSENT

I, _____, give the Mental Health Association, Inc. permission to assist in arranging my routine and preventive medical and dental treatment during the period from ____/____/____to ____/____/____ (not to exceed one year). I understand this includes, but is not limited to, an annual physical, annual dental exam, and a bi-annual eye exam.

I give consent voluntarily, without threat of punishment or promise of special reward. I understand that I may request a full explanation of each procedure at the time of treatment and that I have the right to withdraw consent at any time.

I agree that the results of these exams will be included in my individual record and that I may receive a copy upon request.

_____ _____
Signature of Participant Date

_____ _____
Signature of Guardian Date

I have fully explained the information above and answered all questions to the best of my ability. It is my opinion that consent have been given knowingly and freely.

_____ _____
Signature of Person Obtaining Consent Date

_____
Title

***Protected health information (PHI) is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508.**