Patient Consent Form

Patient Name | **Date of Birth** | **Phone Number**

Authorization and General Consent for Treatment

I hereby consent to and authorize the administration and performance of treatment which in judgment of my (the patient's) healthcare provider may be considered necessary or advisable. I authorize Molina Healthcare, Inc. and its subsidiaries ("Molina Healthcare") including, but not limited to, Molina Care Connections, LLC, ("Care Connections") to release any medical information and Protected Health Information ("PHI") required during the course of examination and treatment.

1. I, the undersigned, grant permission for myself and/or my minor child to undergo all necessary tests, treatments and other procedures in the course of study, diagnosis, and treatment of illness by medical providers of Care Connections.
2. I understand that no guarantees have been made to me as a result of treatment and/or examinations by the medical providers of Care Connections.
3. I consent to the release of medical information and PHI to other physicians, institutions, or agencies accepting the patient for medical or institutional care, and consent to the release of medical information and PHI to the patient's health plan or other entities for treatment, payment or healthcare operations and give permission to release my PHI (medical or personal) to such government agencies as is required of the medical providers of Molina Healthcare and/or Care Connections by law, rules, regulation or by contract. I give consent for Molina Healthcare and/or Care Connections to request and disclose my PHI (medical/personal) for purposes of providing me with medical care and/or treatment.
4. I agree that a photocopy of this consent is as valid as the original.

X

Signature of Patient or Patient's Personal Representative | **Date**

Printed Name of Patient or Patient's Personal | **Relationship**

HIPAA Acknowledgement

We are required to provide you with a copy of our Notice of Privacy Practices ("Notice"), which states how we may use and/or disclose your PHI. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

X

Signature of Patient or Patient's Personal Representative | **Relationship** | **Date**

Consent to Receive Calls, Text Messages, Emails and Telehealth

By providing the above phone number and signature, I understand and agree that**:**

1. Molina Healthcare/Care Connections, and/or its business associates may contact me via phone call, text message, email, and/or telehealth through the use of electronic information and telecommunication technologies (such as audio or videoconferencing) regarding my Molina Healthcare/Care Connections information;
2. The calls, text messages, and/or email may be generated by Molina Healthcare/Care Connections or its business associates by automated dialing and may contain an artificial or prerecorded voice;
3. The texts and/or emails sent to me by Molina Healthcare/Care Connections will not be encrypted. This information can be read by unauthorized persons. It is my duty to keep my mobile phone safe. I understand that Molina Healthcare/Care Connections is not liable for the release of this information once I agree to this consent by signing below; and

X	Self	12/12/2022
Signature of Patient or Patient's Personal Representative	**Relationship**	**Date**

FOR OFFICE USE ONLY We have made good faith effort to obtain written acknowledgment of receipt of Molina Healthcare/Care Connection's Notice of Privacy from the above-named patient, but it could not be obtained because:

- ☐ The patient or his/her personal representative refused to sign
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgment
- ☐ We were not able to communicate with the patient
- ☐ Other (Please provide specific details)

_____

Molina Healthcare/Care Connections Workforce Member Signature

_____

Date