

Columbus Neighborhood Health Centers, Inc.
600 West Spring Street
Columbus, Ohio 43215

Site _____

CONSENT FOR TREATMENT

Name _____ Date of Birth _____ Social Security # _____
(last) (first) (middle)

Address _____
(street) (city) (state) (zip)

Phone (____) _____ Date _____

I give my permission for Columbus Neighborhood Health Center, Inc. staff, medical consultants and other health consultants and/or such other attending physicians or persons that shall have reason for ministering to said client to render all such services as may be necessary to diagnose, treat and care for the needs of _____.

I understand that the information in my medical file **strictly confidential** and that no medical information will be released without my written permission, except that information necessary for invoicing.

I understand that the demographic and identification information within this record will be treated as confidential and will be used exclusively for invoicing and statistical purposes; the client's name will not be used for other than invoicing.

It is understood that Columbus Neighborhood Health Center, Inc, will not be responsible for the loss of any personal item(s) or other valuables.

I also understand that any care received outside the health center (ie. x-rays, specialist care, hospitalization, etc.) will not be paid for by the health center but by me.

Signature of patient/legal guardian

Date

Relationship

Date

Witness/Title

Date