**Consent and Acknowledgment Form\***

I consent to the use or disclosure of my protected health information by Alliance Medical Group to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by Alliance Medical Group may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how my information will be used and disclosed can be found in the Notice of Privacy Practices. I understand that this consent is effective for as long as Alliance Medical Group maintains my protected health information.

**Communication Consent- Phone Calls and Text Messages\***

It is understood and agreed that Alliance Medical Group and/or its authorized agents may contact me, or a representative I appoint, using any contact or cell phone numbers I provide to it, or that may be available by any other means. I expressly agree that Alliance Medical Group may contact me at such numbers by telephone, pre-recorded voice messages and text messages, and may use an automatic telephone dialing system and/or an artificial pre-recorded voice.

This express authorization applies even if I am charged for the call under my mobile phone plan. I agree that such contact will not be “unsolicited” for purposes of local, state or federal law. I further agree that Alliance Medical Group and/or its authorized agents may monitor and/or record any communication with me.

By signing below, I understand and acknowledge the following:

* I have read and understand this Consent and
* I have received a copy of Waterbury Health’s Joint Notice of Privacy Practices currently in effect.

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Patient Print Name Patient DOB Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Representative Print Name Legal Representative Signature Date

**Relationship to Patient:** □ Parent □ Legal Guardian □ Power of Attorney □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To Be Completed by AMG Workforce Member:**

If unable to obtain written consent and acknowledgment:

□ Individual refused □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Emergency treatment situation

□ Individual not able to sign due to incompetence or other medical reason