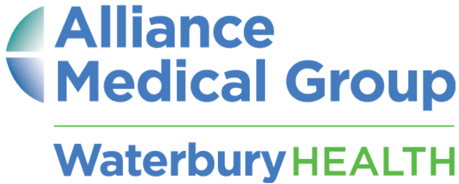

CONSENT & ACKNOWLEDGMENT OF PRIVACY PRACTICES

I consent to the use or disclosure of my protected health information by Alliance Medical Group ("AMG") 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 AMG may include HIV/AIDS related information, mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with both Federal and Connecticut State law. Use of such information may require you to provide specific authorization. I understand that AMG is an affiliate of Waterbury Health and information regarding how AMG will use and disclose my information can be found in Waterbury Health's Joint Notice of Privacy Practices. I understand that this consent is effective for as long as AMG maintains my protected health information.

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.

______________________________	______________________________	___________________
Patient Print Name	Patient Signature	Date
______________________________	______________________________	___________________
Legal Representative Print Name	Legal Representative Signature	Date

Relationship to Patient: ❑ Parent ❑ Legal Guardian ❑ Power of Attorney ❑ Other: __________________

<u>To Be Completed By AMG Workforce Member:</u>

If unable to obtain written consent and acknowledgment:

❑ Individual refused

❑ Emergency treatment situation

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

❑ Other: ____