Name/Nombre: _____ **DOB/ Fecha de Nacimento:**_____

Authorization for Treatment

By signing below, I authorize and consent to the examination, diagnosis, and treatment by the medical and/or dental providers and other healthcare professionals at Finger Lakes Community Health.

I understand that:

1. **Nature of Treatment -** I voluntarily consent to any and/or all health care services, considered necessary or advisable by the healthcare provider. These include, but are not limited to, routine diagnostic procedures, medical or dental treatment, administration of medications, laboratory tests, and other procedures.
2. **Right to Refuse -** I have the right to refuse any procedure or treatment at any time during my care.
3. **Provider Information -** Different healthcare providers at Finger Lakes Community Health, including physicians, physician assistants, nurse practitioners, dentists, and other qualified professionals may treat me.
4. **Telehealth Services -** Telehealth technology may be used in some cases to provide services, and I consent to receive such services, if applicable. Check here if you are opting out of this service: ☐
5. **Emergency Care -** In the event of an emergency, immediate medical care may be provided to me without prior consent, as allowed by law.
6. **Ambient Listening Tools and Artificial Intelligence** – Your doctor might use smart computer tools (i.e. AI or Ambient Listening) that write down what you say during your visit. The computer listens and makes notes, so your doctor doesn't miss any important details. Later, your doctor will check these notes before they become a part of your medical record. Check here if you are opting out of this service: ☐
7. **Call Recording -** I understand that Finger Lakes Community Health records all calls for quality assurance, training, and compliance purposes. These recordings are kept confidential and protected under HIPAA and all other applicable privacy laws. I understand that I can refuse to have my calls recorded and may request alternative communication methods. My refusal to consent will not affect my ability to access services. Check here if you are opting out of this service: ☐
8. **Dismissal from Practice -** I may be dismissed from medical, dental, and/or family planning services at any of the Finger Lakes Community Health facilities for any of the following reasons:
    - Persistent failure to keep scheduled appointments
    - Abusive behavior
    - Persistent refusal to follow medical advice
    - Non-payment for services

Patient Rights:

- I was informed of my rights as a patient of this facility, including my right to receive considerate and respectful care, and to be informed about my treatment options.
- I received the Patient Bill of Rights and the Notice of Privacy Practices, which outline my rights regarding medical care and the privacy of my health information in compliance with state and federal regulations, including HIPAA. I also understand that I can request a copy of both documents at any time and can access a copy posted in the reception area of any Finger Lakes Community Health center.
- I understand that if I ever disagree with receiving services through any of the listed methods—such as Telehealth, Artificial Intelligence, or Ambient Listening—I can revoke my consent for that specific method in writing and deliver it to a Finger Lakes Community Health center.

Signatures - Patient (or Parent/Guardian if Minor):

By signing below, I acknowledge that I have read this authorization, have had service delivery explained and have had any questions answered. I understand and agree to the terms outlined in this Authorization for Treatment. This consent will remain valid for as long as I am a patient of Finger Lakes Community Health.

_____ _____ _____

Patient/Parent/Guardian Name (Print) **Patient/Parent/Guardian Signature** **Date**