INFORMED CONSENT RELEASE

I, _____, voluntarily consent to medical treatment and lab tests as
(Print patient full name)
recommended by BluMine Health. The care provided does not come with any guarantees and I may change providers or chose to seek treatment elsewhere whenever I deem it in my best interests. I acknowledge and have been informed of risks and benefits of various means of receiving medical treatment. I am fully capable of making medical decisions for myself or may delegate a family member to do so if I am unable.

X_____ **Date**: _____

Patient/Parent/Legal Guardian Signature

If Patient is a Minor (under 18):

Print Name Parent/Guardian: _____

Relationship to Minor: _____

Patient Name: _____ **Date of Birth**: _____

PRISMA CONSENT

Here at BluMine Health, we believe that our patients should receive the best quality care possible and have easy access to medical information, even if at times the care is not received through BluMine.

As a result, BluMine Health is now participating in "Prisma", a service that allows a network of healthcare providers to securely identify and receive your accurate and approved medical information. This is a free service available to your healthcare providers who participate in the CommonWell / Care Quality alliance network.

With your consent, BluMine will be able to obtain your health information from this alliance network to better care for you and optimize your health care plan. This information is not shared with anyone except your BluMine professionals and is for the purpose of continuity of care only.

☐ I accept to participate in the CommonWell / Care Quality Program

☐ I **do not** want to participate in the CommonWell / Care Quality Program

By accepting and signing below, I am hereby authorizing BluMine Health to receive and send information, such as hospital records, lab results, and radiology studies, related to my healthcare visits to and from any CommonWell network affiliate with this consent. I understand that the purpose of this disclosure is for continuity of care only and that my PHI ("protected health information") will always be confidential and will not be used in any way to deny medical treatment. I also understand that this consent can be removed by me at any time by written, signed notice.

X_____ Date: _____

Patient/Parent/Legal Guardian Signature

If Patient is a Minor:

Print Name Parent/Guardian: _____

Relationship to Minor: _____