Trinity Health
IHA Medical Group

Group Medical Visit Consent and Authorization Form

Group medical visits are medical appointments conducted in a group setting in which the physician and each patient discuss the patient's personal medical condition and treatment in the presence of the group.

Because each patient will be disclosing personal health and other personal information to the group, participation in group medical visits and the release of personal health information within the group is strictly voluntary and is not required in order to receive treatment from **Trinity Health IHA Medical Group.**

Consent, Authorization to Disclose and Confidentiality Agreement

By signing this Agreement, I consent to participate in group medical visits at **Trinity Health IHA Medical Group.** I authorize **Trinity Health IHA Medical Group** physicians/allied health professionals conducting the group medical visit in which I participate to disclose my personal health information and other private information ("Private Information") in the presence of all participants attending the group medical visit. I also agree to respect the privacy of all participants, including their family members, who attend the group medical visit by keeping their Private Information confidential and not disclosing such information. I acknowledge the possibility that my Private Information may be disclosed by other participants in group medical visits contrary to their Confidentiality Agreement, and I voluntarily assume all of the risks associated with such disclosure. I understand that I may revoke this authorization at any time by delivery of a dated and signed letter to **Trinity Health IHA Medical Group**. I understand that such revocation will not prohibit **Trinity Health IHA Medical Group** from making any disclosures already made or taking any actions already taken in reliance on this authorization prior to the receipt of such revocation. Further, I understand that such revocation will preclude my participation in additional **Trinity Health IHA Medical Group** group medical visits, but will not prevent me from receiving other types of treatment from **Trinity Health IHA Medical Group.**

If not earlier revoked, this authorization will expire at the conclusion of my treatment through **Trinity Health IHA Medical Group** group medical visits.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION INDICATING THE PRESENCE OF CONDITIONS INCLUDING, BUT NOT LIMITED TO, DIABETES, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, HEART DISEASE, DEPRESSION, ANXIETY, CONSTIPATION, GASTROESOPHAGEAL REFLUX DISEASE, OTHER GI CONDITIONS, KIDNEY DISEASE, OBSTRUCTIVE SLEEP APNEA, GOUT, CANCER, AND ARTHRITIS.

PARTICIPANT:

_____
(SIGNATURE)

_____
(PLEASE PRINT NAME)

Date: _____/ _____/ _____

STAFF WITNESS:

_____
(SIGNATURE)

_____
(PLEASE PRINT NAME)

Date: _____/ _____/ _____