CONSENT FOR MEDICAL TREATMENT

I voluntarily request and consent to Hamel Health and On-site Medical Services LLC. ("Hamel Health Associates") medical providers, and any associates, technical assistants, and/or other professionals as such Providers to provide medical treatment and diagnosis.

I understand that Hamel Health Associates employs and/or contracts Providers whose advice, recommendations, and/or decisions may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmission issues. I understand that I must provide information about my medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my knowledge and ability.

I understand that Hamel Health Associates does not guarantee any health outcomes. I will not utilize Hamel Health Associates for life threatening conditions and will seek immediate medical treatment at the nearest emergency room.

I hereby authorize and consent for Hamel Health Associates to share and consult with other healthcare providers I may be seeing for medical treatment such as my primary care provider, specialists, and/or counseling services. I understand that any medical information shared about me is strictly for coordination of care to achieve better health outcomes and will be limited in scope. There are only four (4) circumstances in which a provider is legally and ethically bound to break confidentiality and take appropriate action. 1. Imminent danger or potential for serious harm to yourself or others; (2) when there is reason to believe there is ongoing abuse of a child, elder or disabled person; (3) if you have a reportable communicable disease and (4) under a court order where a court requires the provider to produce records of your care and/or to appear in court.

I understand that Hamel Health uses electronic health records which are stored on a secure system that is separate from the college system and doesn't become part of my academic record. Records will be destroyed after 7 years.

I acknowledge that I have been given a copy of Hamel Health Associates privacy policy. I understand that I am encouraged to review this policy prior to any consultation, evaluation, and/or treatment by Hamel Health Associates.

I have been given an opportunity to ask questions about the services to be provided to me, including any relevant risks and hazards involved with the provision of such services.

Based on the above, I believe that I have sufficient information to give this informed consent for the provision of medical services.

PATIENT NAME: _____ MERRIMACK ID#_____

PATIENT DATE OF BIRTH_____ TODAY'S DATE:_____

PATIENT SIGNATURE (parent if under 18): _____