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Health Network General Consent /Konsantman Jeneral pou Health Network a

MM/DD/YYYY
 DD/MM/AA

Name of patient / Non pasyan an

Date of birth / Dat nesans

Migrant Clinicians Network is a non-profit organization that helps with continuity of care through the Health Network program at no cost to me (or my child). However, MCN cannot guarantee access to all healthcare providers or the quality of care. Providers are independent and not MCN employees. MCN does not provide or oversee treatment or outcomes.

Migrant Clinicians Network se yon òganizasyon san bi likratif ki ede kontinite pran swen atravè pwogram Health Network a gratis pou mwen (oswa pou pitit mwen). Sepandan, MCN pa ka garanti aksè ak tout pwofesyonèl swen sante yo oswa kalite swen an. Pwofesyonèl swen sante yo endepandan epi yo pa anplwaye MCN. MCN pa bay oswa sipèvize tretman oswa rezilta yo.

I consent to MCN using my (or my child's) health and personal information solely for medical treatment, healthcare operations, or as authorized by me. I agree to inform future providers of my (or my child's) MCN enrollment to facilitate record transfers and consent to MCN maintaining sensitive health information.

Mwen dakò pou MCN sèvi ak enfòmasyon sante mwen (oswa pitit mwen) ak enfòmasyon pèsonèl mwen sèlman pou tretman medikal, operasyon swen sante, oswa jan mwen otorize l. Mwen dakò pou m enfòme fiti founisè swen sante m yo sou enskripsyon m (oswa timoun mwen) nan MCN pou fasilite transfè dosye yo ak konsantman pou MCN kenbe enfòmasyon medikal sansib yo.

I authorize MCN and my (or my child's) providers to access these records for treatment.

Mwen otorize MCN ak Founisè swen sante m (oswa timoun mwen) gen aksè ak dosye sa a yo pou tretman.

MCN may contact me about follow-ups and referrals while adhering to confidentiality laws. **This consent is valid for 24 months or until I opt out.** I can request to leave the Health Network program or limit its scope at any time and receive a copy of my (or my child's) records upon request.

MCN gendwa kontakte m konsènan suivi ak referans pandan y ap respekte lwa konfidansyalite yo. **Konsantman sa a valid pou 24 mwa oswa jiskaske mwen chwazi soti.** Mwen ka fè demann pou m kite pwogram Health Network a oswa limite pòte l nan nenpòt ki moman epi resewva yon kopi dosye mwen (oswa timoun mwen) sou demann.

I release MCN and its affiliates from any claims or liabilities related to my (or my child's) Health Network enrollment

Mwen libere MCN ak tout sosyete ki afilye avè l yo pou tout reklamasyon oswa responsabilite ki gen rapò ak enskripsyon m (oswa timoun mwen) nan Health Network a.

Signature of the patient or legal representative /
 Siyati pasyan an reprezantan legal la

Date of Signature /
 Dat siyati an

Phone number / Nimewo telefòn

Signature of Witness / Siyati Temwen an

Date of Signature/ Dat siyati an

A contact person whom Health Network can communicate with who will always know the patient's location.
 Kontak yon moun Health Network ka kontakte ki ap toujou konnen kote pasyan an ye.

Name of contact / Non Kontak la

Phone # N/imewo telefòn

e-mail /imèl

Name of contact / Non Kontak la

Phone # N/imewo telefòn

e-mail /imèl

Name of contact / Non Kontak la

Phone # N/imewo telefòn

e-mail /imèl

For the health care provider or referring partner / Para el proveedor de servicios de salud o entidad que refiere

Gender Farmworker Yes No

Referral Partner: Name and Contact Information

Language: English Spanish Haitian Creole Other _____

Current Location: _____ Traveling to: _____
 (City, State)

Medical reason for requesting continuity of care support from Health Network:

TB Perinatal Care Cancer Diabetes HIV/Aids General Health Pediatrics

Reason : _____

Please attach all medical records (screening results, hospital records , Clinical Notes, etc) to this consent.