Patient Acknowledgment & AI Technology Consent

www.prevhealth.us
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PrevHealth Folsom PC · 800 W MacDade Blvd, Folsom, PA 19033 · Tel: (267) 814-2533 · Fax: (267) 814-2536

PrevHealth
Patient Centric - Tech Enabled

Patient name:	Date of birth:	Date:	MRN (office):

Section 1 — Acknowledgment of Notice of Privacy Practices

I acknowledge that I have received, or been offered, a copy of PrevHealth's Notice of Privacy Practices. The Notice explains how my health information may be used and shared, and describes my rights. Signing this acknowledgment does not mean I agree with the Notice, and my care does not depend on signing it.

Patient (or representative) signature _____ Date _____

Office use only — if acknowledgment was not obtained: ☐ Patient declined to sign ☐ Emergency treatment (obtain at next opportunity) ☐ Other: _____ Staff initials: _____ Date: _____

Section 2 — How PrevHealth uses AI technology

PrevHealth uses artificial intelligence (AI) tools to help our clinicians with documentation, such as transcribing and summarizing your visit and drafting clinical notes. AI tools may also offer suggestions that support, but never replace, your clinician's professional judgment.

- A licensed clinician reviews and approves all AI-generated content. Your clinician makes all diagnosis and treatment decisions.
- We require every vendor that handles your health information, including AI vendors, to sign a Business Associate Agreement and to protect your information as HIPAA requires.
- We do not permit our AI vendors to use your identifiable health information to train or improve their products.
- Audio recordings are used only to create your visit documentation and are deleted once your clinician has reviewed and finalized your visit note. The finalized note becomes part of your medical record.
- Your health information is stored and processed within the United States, except where the law permits otherwise and appropriate safeguards are in place.
- No technology is completely free of risk. We use administrative, physical, and technical safeguards to reduce that risk.

Section 3 — Your choices

Please make a choice for each item. Declining will not affect your care in any way. If you decline, your clinician will document your visit in the usual way.

☐ **I agree** ☐ **I do not agree**	to the use of AI tools to help document my visits.
☐ **I agree** ☐ **I do not agree**	to audio recording of my visits for documentation purposes.

Before any recording begins, your clinician will let everyone in the room know and ask for their agreement. Recording will not start, or will stop, if anyone objects. You can change your mind at any time, including during a visit, by telling your clinician or any staff member. We will note your choice in your record. Changing your mind does not affect information recorded before you told us.

Questions? Contact our Privacy and Security Officer at privacy@prevhealth.us or by calling our office. You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, as explained in our Notice of Privacy Practices.

Patient signature _____ Date _____

If signed by a representative: printed name _____ Relationship / legal authority _____

Authorization to Release or Obtain Health Information

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Complete one form per patient. A parent or guardian signs for a minor, except as noted in Section 7.

1. Patient information

First name:	Last name:	Date of birth:	Phone:

2. Direction of release

☐ I authorize PrevHealth to RELEASE my information to:	☐ I authorize PrevHealth to OBTAIN my information from:
Name of provider / facility / person:	Name of provider / facility / person:
Address:	Address:
Phone:	Phone:
Fax / secure email:	Fax / secure email:

☐ **Send my records to ME (patient request for own records)** — address or delivery method:
_____

3. Purpose

☐ At the request of the patient ☐ Continuing care / new provider ☐ Relocation ☐ Legal / insurance ☐ Other: _____

4. Information to be released

☐ Entire medical record	☐ Immunization record
☐ Visit notes, dates: _____	☐ Lab / test results, dates: _____
☐ Medication list / last well visit	☐ Other: _____
Delivery: ☐ Mail ☐ Pick-up ☐ Fax ☐ Patient portal / secure email	**Format:** ☐ Paper ☐ Electronic ☐ CD (qty: ___)

5. Specially protected information — initial each category you authorize

Pennsylvania and federal law give extra protection to the records below. If you do not initial a category, that information will NOT be released.

Initials	Category
	HIV/AIDS-related information, including test results
	Mental health / psychiatric treatment records
	Drug and alcohol (substance use disorder) treatment records
	Other sensitive information (specify, e.g., genetic testing, STI, reproductive health): _____

This authorization does not cover psychotherapy notes. Releasing psychotherapy notes requires a separate authorization.

6. I understand that:

- PrevHealth will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- I may revoke this authorization at any time by giving written notice to PrevHealth's Privacy Officer. Revocation will not affect information already released in reliance on this authorization.

- Information released to a person or organization that is not covered by federal privacy rules may be redisclosed by them and may no longer be protected.
- This authorization expires 12 months from the date signed, unless I write a different date or event here: _____.
- If I request copies of my own records, PrevHealth will charge only a reasonable, cost-based fee permitted by HIPAA and Pennsylvania law and will tell me the fee before preparing the copies. Records sent directly to another health care provider for my continuing care are provided at no charge.
- I am entitled to a copy of this signed form.

7. Signatures

Patient signature	Date
Personal representative (if applicable): printed name and signature	Relationship / description of legal authority

Minors: Under Pennsylvania law, a minor who consented to certain care on their own (for example, outpatient mental health treatment at age 14 or older, drug and alcohol treatment, pregnancy-related care, or STI testing) controls the release of those records and must sign for them.

Minor's signature (when required)	Date

Office use only

Received: _____ ID verified ☐ Representative authority verified ☐ Fee quoted: $_____ Date sent: _____ Staff initials: _____

☐ HIV redisclosure notice (PA Act 148) attached, if applicable ☐ Part 2 redisclosure notice attached, if applicable ☐ Copy given to patient

GAD-7 Anxiety Screening

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Patient name:	Date of birth:	Date:	MRN (office):

This short questionnaire helps your care team understand how you have been feeling. Please answer each question. Your answers are confidential and become part of your medical record.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid, as if something awful might happen	☐	☐	☐	☐

If you checked any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Office use only — Total score (0–21): _____ 0–4 minimal • 5–9 mild • 10–14 moderate • 15–21 severe Reviewed by: _____ Date: _____

Important: This questionnaire is a screening tool, not a diagnosis. Your clinician will review your answers with you.

If you are in crisis or thinking about harming yourself, call or text 988 (Suicide & Crisis Lifeline), or call 911. Please also tell a staff member right away.

Resources: Anxiety & Depression Association of America — adaa.org • National Alliance on Mental Illness — nami.org • 988 Suicide & Crisis Lifeline — 988lifeline.org

PHQ-9 Depression Screening

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Patient name:	Date of birth:	Date:	MRN (office):

This short questionnaire helps your care team understand how you have been feeling. Please answer each question. Your answers are confidential and become part of your medical record.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

If you checked any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

If you are in crisis or thinking about harming yourself, call or text 988 (Suicide & Crisis Lifeline), or call 911. Please also tell a staff member right away.

Office use only

Total score (0–27): _____ 0–4 minimal • 5–9 mild • 10–14 moderate • 15–19 moderately severe • 20–27 severe

Item 9 answered above 0? ☐ No ☐ Yes → clinician notified BEFORE patient leaves. Clinician: _____ Time: _____ Staff initials: _____