Authorization and Consent for Participation in the PCPCH
Patient Centered Primary Care Home Program

I understand that in signing this Authorization and Consent for Participation in the PCPCH Patient Centered Primary Care Home Program (“PCPCH program”) that I am agreeing to participate with my primary care provider (PCP) in a comprehensive approach to medical care. The PCPCH program is intended to promote information sharing between patients and their PCP care team so that everyone has a complete picture of existing and potential health risks for the purpose of producing better health outcomes. The PCPCH program encourages healthcare team partnerships with the patient and care team to enhance overall care. These partnerships may include my PCP, other physicians/practitioners, specialists to whom I am referred for care or from whom I receive care, and other healthcare professionals involved in the treatment or prevention of medical conditions.

By participating in this PCPCH program, my PCP and the care team have agreed to provide:

- Comprehensive, coordinated care,
- Quality and safety using evidence-based practices, and
- Team based care to include provider leadership, an interdisciplinary care team, and effective staff communications.

By participating in this PCMH program, the patient (parent/guardian) agrees to:

- Ask questions, share your thoughts and be involved in your care,
- Work with your care team to establish and follow a care plan,
- Keep appointments and communicate in advance if you are not able to make an appointment, and
- Commit to work in conjunction with your established care team.

If indicated below, both the care team and patient agree to participate in the PCPCH program, as defined, throughout the duration of the program. Additionally, this agreement may be terminated by either party at any time due to dissatisfaction or other reasons. A copy of this Authorization and Consent will be placed in my medical record, and a copy will be provided to me upon request. This Authorization and Consent extends to information placed in my medical file after the effective date of this Authorization and Consent. I understand I may revoke my decision to participate in the PCPCH Program at any time through a written request to my care team.

Check one: □ Patient Agrees to PCPCH Program        □ Patient Declines PCPCH Program

Patient Name (printed): ___________________________________________ Date: ________________

Patient Signature: _______________________________________________

Parent/Guardian Signature: _______________________________________

For Office Use Only:
□ Entered in electronic record
□ Pt declines – notification sent
□ Verbal agreement/declination received (date/initials): _________________

Updated 6/2012