ALOHA MALAMA HEALTH
HEALTH CARE BELONGS TO EVERYONE

Informed Consent for Treatment

I hereby authorize Aloha Malama Health provider(s) under Mana Psychological Services Corp. to perform, diagnose and treat according to the professional standards and their own professional judgment. I understand that my medical treatment may include a variety of medical modalities including, but not limited to, pharmaceutical management, laboratory testing, imaging, dietary counseling, acute and chronic medical condition management.

I understand that there are unforeseen risks and adverse effects associated with any medical treatment or procedures. I have been informed about possible side effects and benefits. Pharmaceutical treatment risks and adverse effects are extensive and drug-specific, and will be discussed as needed, pending the medication(s) being prescribed.

I understand that no promises or guarantees can be made regarding the outcome of treatment and procedures and that all reasonable efforts will be made to provide information to me so I make an educated, informed decision about my medical treatment and care. All my questions have been answered to my satisfaction.

In the event I am referred to another medical professional, I understand that Aloha Malama Health under Mana Psychological Services Corp. may share appropriate and necessary protected health information (PHI) (under the HIPAA law), necessary for the other provider to provide the best, most appropriate care.

I permit Aloha Malama Health under Mana Psychological Services Corp. to call my home or alternative location and leave a message on voicemail or in person pertaining to my medical care, including laboratory, radiological, and pathological results. I authorize the use of electronic health records from Aloha Malama Health under Mana Psychological Services Corp.

Patient Name (Print) _____ Date _____

Patient signature _____ Date _____