Patient Name: Remco Van Latum - Date Of Birth: 1974-10-23

1. I hereby authorize Metro Community Health Centers (Metro CHC) and/or its staff, including physicians, dentists, nurses and other staff to provide such medical and/or dental care and to administer such routine diagnostic tests and procedures, including, but not limited to: diagnostic x-rays; physical examination(s), administration and/or injection of pharmaceutical products, including routine immunizations and medications; drawing of blood specimens, use of local anesthesia and other non-invasive procedures as in the judgment of Metro CHC's personnel and/or my/the patient's physician(s) are deemed necessary or advisable in my/the patient's care. I acknowledge that this consent includes all future appointments and care rendered, and that further consent is not necessary unless I revoke this consent in writing.

2. I acknowledge that medicine is not an exact science and that diagnosis or treatment may involve risk of injury or even death, and no guarantees or assurances have been made to me concerning the results of treatments or examinations at Metro CHC.

3. Metro CHC may have the ability to access prescription medications I have filled or taken elsewhere, through connecting to medication history data as reported through pharmacy benefit managers or otherwise. Knowledge of other medications can help my doctor know whether there may be drug interactions or whether symptoms may be caused by a medication. Metro CHC has no responsibility as to accuracy of data obtained. I authorize Metro CHC to access this information.

4. I understand that Metro CHC supports education and training and may provide clinical opportunities for trainees in various disciplines. I understand that I have the right to refuse to have a trainee participate in my care.

5. I authorize Metro CHC to dispose of or use specimens taken for laboratory, pathology or other purposes.

6. I understand my (patient's) rights and responsibilities as a patient.

7. OCCUPATIONAL EXPOSURE: Regardless of whether I consent to elective HIV testing as set forth in Section 8 below, unless I cross out this provision, if a healthcare worker involved in my care and treatment becomes exposed to certain bodily fluids resulting in the possibility of transmission of a blood borne disease, my blood will be tested for HIV, Hepatitis B and Hepatitis C to determine risk of exposure.

8. HIV TESTING: Your Health Care Provider is required to make an offer of HIV testing as part of routine care to all persons between ages 13 and 64. You are strongly encouraged to accept testing since, as with other medical screenings, it may provide you with important information about your health and give you what you need to make good decisions for staying healthy. I have been given information regarding HIV, including seven points of information regarding HIV testing, how HIV can be transmitted, that there is treatment for HIV/AIDS, how to keep myself and others safe from HIV infection, that testing is voluntary and can be done anonymously, how my HIV-related information will be kept confidential and what laws protect people with HIV/AIDS from discrimination. I understand that the results of my HIV test will be documented on my medical chart. My consent may be given orally and documented by Metro CHC.

Please select one of the following: : I do not want an HIV Test at this time.

9. I understand that if I disagree with particular provision listed above, I have the right to cross out any provision and will initial next to my cross-out so that Metro CHC knows that I refused that provision.

I confirm that I have read/ or have had read to me the information above. I further confirm that I fully understand the above information and all my questions have been answered.

Patient/Guardian/Personal Representative:

Printed Name: Remco Van Latum

Relationship if not patient:

Signed on 2020-06-01