University Hospitals

UH General Consent

(please print)

GENERAL CONSENT

GENERAL CONSENT-SERVICE WILL NOT BE PROVIDED TO ANYONE WHO CHANGES OR ALTERS THE TERMS OR LANGUAGE OF THIS CONSENT FORM

Authorization for Treatment

[Patient/Patient's legal representative] agree to permit authorized personnel of University Hospitals [the Hospital] to perform such diagnostic and therapeutic procedures that my treating physician(s) deem necessary for care. By signing below I agree to permit xrays, laboratory tests, photographs for treatment purposes, routine medical treatment (for example, medications, injections, drawing blood for tests), emergency procedures as necessary and hospital services performed at the request of physicians arising in my care. I understand that, except in an emergency, any further treatment or procedures will be performed only after I have been informed of the benefits, material risks and complications associated with such treatment or procedures and I have given my consent. I further understand that the Hospital is a teaching institution and that physicians, nurses and other healthcare personnel in training may assist, be present and participate in providing my care and that my medical records may used for educational purposes.

I recognize and understand that the physicians, including, but not limited to emergency department physicians, who provide services at the Hospital, with the exception of residents, are independent practitioners and not employees or agents of the Hospital. The Hospital is not responsible for the acts or omissions of physicians who are not directly controlled by the Hospital.

Authorization to Release Information

The undersigned hereby permits University Hospitals, the Hospital, its affiliated health care providers, and/or their authorized personnel to access and/or release all or any part of the patient information (including information regarding substance abuse, HIV testing, AIDS and psychiatric treatment) to, including but not limited to, the appropriate healthcare insurer(s), employers for work-related injuries, third party payor(s), students receiving education or training in healthcare, participants in the Clinisync or other health information exchange(s), and/or the Hospital's agent(s), attorney(s) and/or consultant(s) for purposes including treatment of the patient, billing (or collecting payment) for services and healthcare operations including improving patient care, training or educating students, performance improvement initiatives, discharge planning, risk management, personal health record or other systemwide program(s) designed to foster interaction with patients via electronic means, and/or as required by law. The undersigned hereby permits its affiliated healthcare providers and/or their authorized personnel to access electronic prescription data.

Assignment of Benefits

In consideration of the Hospital's and/or physician(s)'s services received or to be received for medical/surgical services, I assign to the Hospital and/or my physican(s), all benefits herein specified, not to exceed the above hospital/physician(s) charges. I direct such insurer(s) to pay such benefits directly to the Hospital and /or my physician(s). I hereby agree to pay any and all hospital and/or physician(s) fees that exceed or that are not covered by my insurance coverage and waive any and all notices and demands in the event of nonpayment.

Medicare/TRICARE/Champus Payment /Notice of Privacy Practices

I certify that the information I gave if applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including TRICARE/Champus claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Record Retention Policy

The Hospital retains patient medical records in accordance with applicable law and pursuant to its record retention policies.

Computer Data

I understand that my medical records will be accessible to authorized Hospital personnel through computers and that the Hospital will comply with certain safeguards established by federal state and local law as well as Hospital policy.

Certification

I certify that to the best of my knowledge and belief the information provided is complete and correct. In understand that this consent is subject to revocation by me at any time except if the person or entity authorized to make a disclosure has already acted in reliance on the form. Otherwise, subject to applicable law, this consent will expire at the same time the Hospital's record retention period for this document expires.

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Patient Personal Property/Payment for Non-Reimbursable Items

I understand that the Hospital is not responsible for loss or damage to money and valuables, unless these are placed in the hospital safe. I understand and agree to pay the charges incurred by me or on my behalf for personal use and/or convenience items and hereby authorize the hospital to bill me or an applicable party for such use and I agree to pay or otherwise arrange for and ensure payment of the same.

Other Uses of Medical Information

The undersigned hereby understands and recognizes that University Hospitals, the Hospital, its affiliated health care providers, and/or their authorized personnel have access to medical information which may be used by UH and its research personnel for research related purposes. The use of medical information for research related purposes is subject to Federal and State laws and regulations, as well as Hospital policies regarding research studies.

Additional Permitted Uses and Disclosures of Confidential Medical Information

The undersigned understands and consents to disclosure of confidential medical information to a State or Federal Health Oversight Agency an appropriate Public Health Authority for purposes required by State and/or Federal Law in cooperation with a Law Enforcement Investigation in cooperation with a domestic or child abuse investigation to organ procurement organizations and for any other permissible purpose as outlined in University Hospitals Notice of Privacy Practices.

Notice of Privacy Practices - Acknowledgment

PLEASE CHECK THE APPROPRIATE BOX:

1. ☐ Yes ☐ No ☐ N/A — I acknowledge that if I am a Medicare and/or Champus/Tricare Beneficiary, I have been provided with a copy of the notice from Medicare and/or Champus/Tricare regarding my rights as a Medicare and/or Champus patient and that the form has not been altered.
2. ☐ Yes ☐ No ☐ N/A — I agree to release my Social Security number to the manufacturer of any medical device that I may receive, in accordance with both federal law and regulations. I further understand that my Social Security Number may be used by the manufacturer to help locate me if there is a need to contact me regarding my use of a medical device. I release the Hospital from any liability that might result from the disclosure of this information.
3. ☐ Yes ☐ No ☐ N/A — I hereby agree to be liable for and pay the Hospital the difference between the established hospital rate for the private room accommodations and the payment rate provided for in my benefits contract.
4. ☐ Yes ☐ No ☐ N/A — I acknowledge receipt of a copy of the Notice of Privacy Practices ("NOPP").
   If no, reason acknowledgement of NOPP not received: _____

I AM THE PATIENT OR AUTHORIZED TO SIGN THIS DOCUMENT. I HAVE READ ALL THE ABOVE AND UNDERSTAND ITS TERMS.

Printed Patient Name	Hospital No.	
Signature of Patient	Date	Time
Signature of Legal Representative, if patient is unavailable	Relationship	Date
		Time
Witness	Date	Time