SUMMIT MEDICAL CENTER

Consent for Admission & Treatment

Place Patient Label Here

CONSENT TO MEDICAL CARE: I request admission to SUMMIT MEDICAL CENTER and authorize the facility, staff and physicians to provide care. I request and consent to medical care and diagnostic procedures that my attending physician(s), or his/her designees, determine are necessary. I acknowledge that the medical care I receive while in SUMMIT MEDICAL CENTER is under the direction of my attending physician(s) and that SUMMIT MEDICAL CENTER is not responsible for acts of omission of my attending physician(s). I authorize SUMMIT MEDICAL CENTER to retain or dispose of any specimen or tissue taken from the above named patient.

TEACHING PROGRAMS: I understand that this SUMMIT MEDICAL CENTER is a facility that promotes education opportunities, and therefore, I understand that I may be seen and examined by supervised participants as a part of the educational program. I agree to participate in these programs, but reserve the right to limit my participation at any time.

DISCLOSURE OF INFORMATION: The undersigned agrees that all records concerning this patient's hospitalization shall remain the property of the facility. The undersigned understands that medical records and billing information generated or maintained by the facility are accessible to facility personnel and medical staff. Facility personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care for this admission. The facility is authorized to disclose all or part of the patient's medical record to any insurance company, third party payor, workers compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of patient's account. Law requires that the facility advise the undersigned that **THE INFORMATION RELEASED MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWS AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).** The facility is authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing. By signing this form, you are authorizing such disclosures.

SPECIAL CONSENT FOR HIV TESTING: The undersigned specifically consents to the testing of the patient's blood or human immunodeficiency virus (also known as AIDS) and/or Hepatitis if determined by the patient's attending physician to be necessary (i) for determining the appropriate treatment and/or treatment procedures for the patient or (ii) for the protection of the attending physician and/or any employee or agent of the facility or the attending physician exposed to the bodily fluids of the patient in a manner which could transmit such disease. The undersigned has been informed about the nature of the blood test, its expected benefit, and has been given the opportunity to ask questions about the blood test.

I (we) authorize SUMMIT MEDICAL CENTER and/or my physician and/or physicians to photograph/video or permit other persons to photograph/video for such purposes as may be deemed necessary.

I (we) consent to the presence of students, residents or fellows, and vendors in the operating room to observe the procedure. I am aware that only the physician may grant this permission on my consent.

ADVANCE DIRECTIVE AND ORGAN TISSUE DONOR: The patient, or his/her representative, hereby acknowledges having been provided with information regarding patient rights and patient's right to prepare an advance directive. The following documents have been executed:

Advance Directive and/or Living Will	☐ Yes	☐ No
Would like more information on Advance Directives	☐ Yes	☐ No
Medical Durable Power of Attorney	☐ Yes	☐ No
Have you received a copy of the Bill of Rights?	☐ Yes	☐ No
Do you have a legal guardian?	☐ Yes	☐ No

Please provide name: _____

PATIENT RIGHTS: I acknowledge receipt of information explaining my rights as a patient and, on request, I received a copy of the State notice and this facility policy statement regarding Patient's Right to Self-Determination.

I have been informed that my physician may be a partner in ownership of SUMMIT MEDICAL CENTER. I have the right to review a list of partners. The physicians and Allied Health Professionals (AHPs) practicing at SUMMIT MEDICAL CENTER are licensed and/or credentialed to practice in this facility. The physicians and AHPs provide medical services at SUMMIT MEDICAL CENTER, but they are not agents or employees of SUMMIT MEDICAL CENTER.