North Memorial Clinic

Patient:
MRN:
DOB:

Consent for Services

A. Consent for Treatment. I consent to the physicians, referral physicians or their assistants, and designees of North Memorial to examine, treat, complete tests, complete routine procedures and to administer such medications considered necessary or advisable.

B. Blood / Exposure Testing: I understand that if a health care worker is accidentally exposed to my blood or other body fluid my blood will be tested for the presence of bloodborne pathogens (hepatitis B, hepatitis C, and human immunodeficiency virus) in accordance with public health policy in order to protect and counsel the exposed individual. The results of such tests will be part of my medical record and will not be released except as required or permitted by law.

Screening for human immunodeficiency virus may be done if determined by a physician to be appropriate in accordance with public health policy.

C. Release of Medical Records. I agree that information from my medical record may be used by or given to physicians, referring providers, staff, and/or business associates as necessary for treatment and healthcare operations, so long as any release of information is in compliance with the law.

D. Release of Medical Records for Medical or Scientific Research. Medical records, regardless of when generated, may be released for the purpose of medical or scientific research unless a written objection is completed. This release may be revoked by me in writing at any time.

E. Disclosure of Presence. I understand that during my visit my friends, family, or others, may call to inquire about my presence at North Memorial. I authorize North Memorial to disclose information about my presence and/or location at this facility to anyone who may inquire about me by name. This may, when appropriate, include a one-word description of my condition: critical, serious, fair or good.

F. Personal Property. I understand North Memorial is not responsible for the loss of any valuables.

G. Payment and Insurance Consent. I request that payment be made to North Memorial on my behalf for any services furnished me by North Memorial, including physician services. I authorize any holder of medical or other information about me to release to any insurance company/payor responsible for payment, any information needed to secure payment. I agree to pay North Memorial for all charges not covered by any third party. I agree to the release of information to any payor or external vendor chosen by a payor to meet authorized utilization review and quality reporting requirements

H. I have received a copy of the North Memorial Notice of Privacy Practices.

I. Consent to Disclose Information. The following consent is on behalf of third party payors. I authorize my insurance company or health plan administrator to share my records with North Memorial about services that I have received from hospitals, clinics, physicians, and other care providers that are unrelated to North Memorial. My insurance company or health plan administrator may share my North Memorial records with a health care provider system or accountable care organization in which North Memorial participates. These records allow my insurance company or health plan administrator to share information within the care provider system or accountable care organization to better coordinate my care and to improve the quality of the care I receive.

By signing below, I consent to all of the above and I acknowledge that I have received a copy of the North Memorial Notice of Privacy Practices.

Date _____ **Time** _____

Verbal/Telephone consent obtained by:

_____

Witnessed by:_____

Reason patient unable to sign:

_____

_____

Signature of Patient or Patient's Representative

(If Patient's Representative, under what legal authority are you signing?)

☐ Parent ☐ Guardian ☐ Health Care Agent

☐ Other (specify): _____

Follow-Up:

Date: Initials: Note: