HEALTHCARE
MARYLAND
CONSENT TO HEALTH CARE SERVICES
AND AUTHORIZATION TO RELEASE INFORMATION

PATIENT NAME: _____ **PATIENT ACCT#:** _____

1. I(or_____acting on my behalf) recognize that I have a condition requiring health care services, and do hereby consent to the rendering of such care and services, which may include routine diagnostic procedures, laboratory and drug testing and such medical treatment as my private physician, staff and attending physician(s) or others on the staff of HealthCare consider to be necessary. I acknowledge that no guarantees have been made to me as to the result of examination and/or treatment provided by SAHC. I understand that treatment rendered to me on an emergency basis is not intended to be comprehensive in scope and that it may be necessary to select additional care providers and make arrangements for a complete diagnosis and continuation of treatment.

2. I understand that many of the physicians on the staff of SAHC, including the attending physician(s), radiologists, pathologists, anesthesiologists and emergency room physician(s), are not employees or agents of but, rather are independent contractors who have been granted the privilege of using facilities for the treatment and care of patients.

3. I understand that photographs, videotapes, digital, or other images may be recorded to document and assist in my clinical care, and/or medical education and I consent to this. I understand that will retain the ownership rights to these photographs, videotapes, digital or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in SAHC's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

4. I understand that except in emergency or extraordinary circumstances, no substantial procedures (i.e. surgical procedures, insertion of scopes, administration of blood/blood products) will be performed upon me or course of treatment undertaken unless and until I, or_____ acting on my behalf, have the opportunity to discuss such procedures and/or treatment with the physician or other health professional and consent to proceeding. I know that I may refuse to consent.

5. I understand that medical records are the property of and are maintained for the benefit of the patient, the medical staff and . I have been informed about how SAHC may use and disclose protected health information about me for treatment, payment and health care operations, and by my signature affixed below, to authorize such use and disclosure without restriction. I agree to participate in the discharge planning process and allow the release of my records and information to outside facilities as needed.

6. This form has been fully explained to me, and I am satisfied that I understand its content and significance. I further understand that a photocopy of the consent shall be as valid as the original on file.

7. If I am an obstetrical patient admitted to the hospital for delivery of a baby, these consents apply to my infant.

8. The HealthCare Joint Notice of Privacy Practices was received on 12/09/03

If patient is unable to consent or is a minor, complete the following:
_____Patient is a minor_____years
_____Patient is unable to consent because_____

_____ _____
SIGNATURE OF PATIENT/LEGAL GUARDIAN or CLOSEST RELATIVE **SIGNATURE OF WITNESS**

SIGNATURE DATE: _____