



# Orange City Area Health System

## MEDICAL CONSENT AND RELEASE OF INFORMATION

### FOR ALL FACILITIES USE:

#### CONSENT FOR TREATMENT

I, knowing that I have a condition requiring diagnosis and medical or surgical treatment, do hereby consent to the following:

1. All medical and surgical treatment, x-ray, laboratory and other medical and hospital procedures as may be performed or prescribed by my physician or any person (including other physicians to be consulted, assistants and hospital personnel) who may be designated. I acknowledge that Orange City Area Health System conducts training programs in which students or practitioners in areas of health care learn under supervision and may be involved in my case. I further acknowledge that no guarantees have been made to me as a result of treatment or examination in the hospital.
2. To testing for HIV (AIDS) and/or Hepatitis should a health care worker have accidental exposure to my blood or other body substances.

#### AUTHORIZATION OF BENEFITS

I consent to release of my medical information for payment purposes to health insurers or third party payers. I hereby authorize payment directly to the provider for insurance benefits otherwise payable to me, but not to exceed the balance due of the provider's regular charge for this period of hospitalization. **I understand that I am financially responsible to the provider for charges not covered by this authorization.**

### INPATIENT / OBSERVATION:

#### RESPONSIBILITY for PERSONAL VALUABLES

I hereby release this facility or hospital employee from liability of lost or stolen articles.

#### PATIENT PRIVACY

##### ***For those 18 & older***

*(If under 18 [or unable to] parent/guardian will need to answer these questions)*

\* May we include your name in our patient directory?  
\_\_\_ Yes \_\_\_ No

\* May we disclose your presence to clergy?  
\_\_\_ Yes \_\_\_ No

Church Affiliation: \_\_\_\_\_

#### **\*\*INFORMATIONAL NOTICE TO ALL PATIENTS\*\***

Orange City Area Health System does not have a doctor of medicine or doctor of osteopathy on the premises 24 hours a day, 7 days a week.

Should you have an emergent condition arise at a time in which there is not a physician on site we will notify the physician on call. The physician then will come to the hospital to address the emergent condition.

#### **I certify that I understand and authorize the above information**

Signature of Patient/Responsible Party X \_\_\_\_\_

Patient Name \_\_\_\_\_ Patient's DOB \_\_\_\_\_

Relationship to patient: \_\_\_ Self \_\_\_ Parent \_\_\_ Spouse Other: \_\_\_\_\_

Employee's Initials \_\_\_\_\_ Date \_\_\_\_\_