Wayne Memorial Hospital
AUTHORIZATION FOR HOSPITAL TREATMENT

* C O N S E N T *

Patient's Name:_____

1. **CONSENT FOR TREATMENT:** I, the undersigned, request and authorize the Hospital and all its physicians, surgeons, technicians, nurses, and other qualified personnel, whether employed directly by the Hospital or brought in on a consulting basis, to provide any medical/surgical treatment, diagnostic tests and hospital care which the attending physician or designee(s) may deem necessary or beneficial for my health.

   I understand that the results of any treatments, tests or care cannot be guaranteed. I also understand that I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law.

   I understand that medical, nursing, and other health care personnel in training may be observing and participating actively in my care under the supervision of authorized personnel. I hereby give my consent to such observations and/or participation.

2. **RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES:** I have been made aware that the Hospital provides special facilities for the safekeeping of valuables. I release the Hospital from any responsibility for the loss or damage to any valuable possession (including valuables brought in to me by other persons) that I choose to keep in my personal possession and do not deposit with the Hospital for safekeeping.

3. **RELEASE OF INFORMATION:** To obtain payment for services, I authorize the Hospital to furnish and release to my insurance carrier(s) or their representatives insuring the patient named, any or all portions of my medical record which may be necessary for completion of my patient care insurance claims. I understand that billing agencies for specialized services such as radiology, emergency services, and anesthesia will also receive information necessary for billing. I authorize the access to or release of my health information to any health care facility or home care provider to which I may be transferred or referred. I further authorize access to or release of my health information to any physician, involved in providing my care. I authorize Wayne Memorial Hospital to obtain my medication history utilizing an electronic information exchange and understand that this protected health information may provide valuable information for my healthcare provider. I hereby release the Hospital from all legal liability that may arise from the release of the information requested and provided. A photocopy of this authorization shall be as binding as the original.

4. **ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY:** I request that payment of authorized benefits be made on my behalf and do hereby authorize payment directly to Wayne Memorial Hospital and/or its physician's of any benefits that otherwise would be payable directly to me for this period of hospitalization or treatment. I understand that I am financially responsible to the hospital and/or physician for charges not covered by this authorization.

5. **CONSENT TO CONTACT** - If, at any time, I provide a telephone number (including wireless telephone) email address or similar electronic means to contact, I consent to receive such communications from Wayne Memorial Hospital. I consent to receive calls and texts (including autodialed calls, texts and prerecorded messages) at the number provided from Wayne Memorial Hospital, its successors and assigns, and its affiliates, agents and independent contractors, including servicers and collection agents, regarding the services rendered, hospitalization, and/or my related financial obligations.

6. **CONSENT TO PHOTOGRAPH:** I consent to the taking of photographs by a staff member of Wayne Memorial Hospital while under the care of this facility. I understand that the images will be stored in my legal medical record located within Wayne Memorial Hospitals Medical Record Department. I understand that these photographs will only be released when required by law or when the patient or the patient's authorized representative gives permission to release the medical record. The undersigned does not authorize any other use to be made of these photographs. My signature below indicates that I have read the above or it has been read to me and I grant permission to Wayne Memorial Hospital to take photographs.

   I hereby agree that any dispute or litigation commenced in connection with or as a result of the care provided Wayne Memorial Hospital shall be filed only in Wayne County, Pennsylvania, and I agree that venue for any such dispute or litigation shall rest exclusively within said county.

   I have read this consent form, I have had it explained to me and understand its contents. I hereby agree to all terms and conditions set forth above.

   Patient Rights & Responsibilities Brochure _____ Received _____Declined.

_____ Date and /Time of Signing

_____ Patient's Signature

_____ Witness to Signature

_____/_____ Authorized Representative's Signature & Relationship (if patient unable to sign)

Affix Patient Label