Ambulatory Care and/or Pre-Surgical Testing Consent

By signing below I consent to receive treatment and for the use and disclosure of my health information to provide treatment, arrange for my medical care, seek and receive payment for services provided to me and for the business operations of the Hospital and its staff.

I understand that with my permission, photographs/video and/or voice recordings may be taken of me and used for medical or scientific purpose such as documenting or planning my care, teaching or publication in a scientific journal. I understand that every attempt will be made to conceal my identity (name) prior to publication in a scientific journal or display of the photographs/video and/or voice recordings. I understand that the photographs/video and/or voice recordings taken to document my care may be a part of my medical record and those taken for other purposes may not be a part of my medical record.

I have been provided a copy of the SBOHCA Notice of Privacy Practices (Notice) on, or prior to this visit, and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed at the beginning of the Notice, and how I may obtain access to and control this information.

I acknowledge the receipt of the Ambulatory Care Patient Guide on, or prior to this visit.

I understand this authorization, for the use and disclosure of my health information to provide treatment, arrange for my medical care, seek and receive payment for services provided to me and for the business operations of the Hospital and its staff, may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 12 months from the date signed.

I also understand I may refuse to sign this form and that my health care and payment will not be affected. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I may request a copy of this form after signing.

Signature of Patient or Patient Representative _____ Date _____ Time _____

Print Name of Patient or Personal Representative _____ Date _____ Time _____

Relationship, if signed by person other than Patient _____ Date _____ Time _____

Signature of Witness _____ Print Name of Witness _____

Date _____ Time _____