VALENTINE MEDICAL CENTER
PATIENT CONSENT FORM

(Please read and sign)

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments, including surgical procedures
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Performance of diagnostic procedures/test
- Taking and utilization of cultures
- Performance of other medical accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. **The consent will remain in full force until revoked in writing.** I understand that Valentine Medical Center includes consent at satellite officers under common ownership. I, the undersigned, acknowledge that Valentine Medical Center will use and disclose my information for the purposes of treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medications; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending practitioner or their assigned designees, may be consider medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Valentine Medical Center of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer of designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but not limited to: release of my medial information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of care.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious disease including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

I acknowledge that I have been given Valentine Medical Center Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Officer. Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature **Date**