MUNSON HEALTHCARE

AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

Form 2280 (10/19)

CONSENT FOR TREATMENT: I have a condition requiring medical treatment and I am consenting to the procedure(s), care and treatment believed to be necessary by my doctor(s), the medical staff and other healthcare professionals of the Facility identified on this form and in this document referred to as the 'Facility'. I understand that many of the physicians and health care professionals providing treatment and services to me at this Facility are independent contractors and are not employed by this Facility. I understand that I have the right to refuse consent to any proposed care, treatment, testing, surgery or procedure. I understand that in certain situations, my care may be given via telehealth and/or in a teaching environment and doctors, nurses, and other health care professionals in training, may be involved in my care and treatment. I have the right to ask questions and discuss my concerns with my healthcare provider.

I am aware that the practice of medicine and surgery is not an exact science. I understand that diagnosis and treatment involve risks. I acknowledge that no promises can be made to me as to the outcome of my care, examination or treatment, or that everything will go as planned.

RELEASE OF MEDICAL INFORMATION: I understand that the Facility may disclose all or any minimally necessary portion of my patient medical record information to attending physicians, consulting physicians, nurses, pharmacists, technicians, medical students, dieticians and other health care providers. This includes people or entities not employed by the Facility who have a legitimate need for this protected health information (PHI) for my care and continued treatment. I authorize the Facility to release to all insurance companies, third party payers (to my employer, if workers' compensation or employer service, if I am hurt at work) and utilization review organizations any information contained in my preadmission, outpatient, emergency room, hospital admission or medical record for the purposes of determining insurance coverage and eligibility, billing claims management, medical data processing, and reimbursement.

Additionally, I am aware that the Facility may maintain both electronic and paper-based documentation of the medical care received. I understand and agree that the information shared will happen by means considered most appropriate to the circumstance by the Facility, including: photocopy, electronic file transfer, facsimile and computerized information systems. I understand that the Facility may be required to allow governmental agencies to review medical records and may provide information to third parties for quality control purposes.

I understand that this health information may include the use of information that may be related to drug or alcohol treatment, psychiatric care, HIV testing, AIDS (Acquired Immune Deficiency Syndrome), HIV infection or ARC (AIDS Related Complex). I am aware that the Facility is compliant with HIPAA ordered administrative, physical, and technical safeguards designed to protect my PHI per HIPAA and 42 CFR Part 2, where related.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT: I request payment of Medicare benefits or other insurance benefits due to me or on my behalf be made directly to the Facility for any services provided to me, including doctor services. I understand that the services of doctors and other healthcare professionals may be billed separately from those of the Facility.

I understand that I am responsible for any health insurance deductibles and coinsurance amounts and I acknowledge that this assignment does not relieve me of my duty to pay my medical and hospital bills if the insurance company does not pay them. I certify that all the information given for payment of my medical and hospital bills (including information required under the Medicare and Medicaid programs) is correct. I am aware that any disagreement about payment of my Facility bill will be settled in the county in which the Facility is located. I also agree that I am responsible for the Facility's actual costs incurred if collections are involved, including lawyer fees or court costs. I approve the Facility, agents, collection agency or lawyers to contact me via autodialed or prerecorded message at the phone number given, whether wireless or landline.

I also approve the Facility, agents, collection agency or lawyers to access my personal credit file to determine charity care qualification or to collect any outstanding or past due money owed.

For any treatment arising out of a motor vehicle accident, I assign to the Facility my Michigan no-fault insurance act rights to claim and enforce payment of charges incurred by me (including any interest and/or fees) for past or present medical care provided by the Facility.

ACKNOWLEDGEMENT OF NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES: A notice of Patient Rights and Responsibilities is available to me upon request. This ensures that I am treated with respect and dignity, without discrimination.

ACKNOWLEDGEMENT OF HIV (HUMAN IMMUNODEFICIENCY VIRUS) TESTING LAW: I understand and consent to testing for HIV (Human Immunodeficiency Virus – AIDS), hepatitis (liver disease), and/or other blood carried agents causing work related risk that may be performed on me if a health care professional, or first responder (police, firefighter, paramedic, etc.) sustains an exposure to my blood or other bodily fluids. I understand that Michigan law permits this testing.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: The Facility's Notice of Privacy Practices describes the specific meanings of 'treatment', 'payment', and 'health care operations' and how the Facility may use and disclose my health information to carry out these functions. **I acknowledge that I have been offered a copy of the Facility's Notice of Privacy practices.**

You are receiving health care at a facility that is part of Munson Healthcare. Munson Healthcare includes the following and is named within this document as "Facility."

☐ Kalkaska Memorial Health Center	☐ Munson Healthcare Grayling Hospital	☐ Munson Home Health
☐ Munson Healthcare Cadillac Hospital	☐ Munson Healthcare Manistee Hospital	☐ Munson Medical Center
☐ Munson Healthcare Charlevoix Hospital	☐ Munson Healthcare Otsego Memorial Hospital	☐ Paul Oliver Memorial Hospital

I HAVE READ OR HAD READ TO ME AND UNDERSTAND THE CONTENT OF THIS CONSENT FORM IN ITS ENTIRETY. ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

X _____

SIGNATURE OF PATIENT/PARENT OF MINOR/*LEGAL GUARDIAN OR REPRESENTATIVE (RELATIONSHIP, IF NOT PATIENT) DATE TIME

** If signing as a court appointed legal guardian/patient advocate assigned by a durable power of attorney in the case of a minor or/adult without the capacity to make his or her own decisions regarding medical treatment, you certify that you are the legally appointed representative of this minor or incompetent adult.*

X _____

SIGNATURE OF WITNESS (Staff acknowledges patient, parent of minor, or legal guardian/representative has signed giving consent for treatment) DATE TIME

Reason acknowledgement could not be obtained: _____