HEALTHSOURCE SAGINAW
SAGINAW, MICHIGAN

CONSENT FOR DIAGNOSIS AND TREATMENT
CONSENT FOR RELEASE OF INFORMATION
AND OTHER RESPONSIBILITIES

I, _____, hereby voluntarily request, consent to and authorize my attending physician (or the staff physician who may be assigned by the hospital), his associates, assistants or other practitioners, under his orders to treat me at HealthSource Saginaw and to provide medical treatment and hospital care, including but not limited to diagnostic procedures, x-rays and administration of medications as is deemed necessary and advisable.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me as the results of the care and treatment which I have hereby authorized.

I hereby authorize HealthSource Saginaw, its Director, or designee, or Medical Records Department, to release information contained in my patient record, including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any: psychological services records, if any; social services records, if any; psychiatric records, if any; including communications made by me to a social worker, psychologist, or psychiatrist, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and Aids Related Complex (ARC) records, if any; communicable disease and infection disease records as defined by Michigan Department of Public Health Rules which include venereal disease and tuberculosis records, if any; to the individuals or organizations requesting, including third party payors responsible for payment.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance of it, and that in any event this consent shall expire 6 months after the date of patient discharge unless another date is specified. Specific date, event or condition upon which consent expires:

In the event a hospital employee is exposed to my blood through skin injury or contamination of mucous membrane, I understand that the hospital can perform a test on my blood for determination of current HIV status and any blood borne pathogen (example Hepatitis).

I take full responsibility for retaining in my possession personal articles of clothing, valuables, or papers while I am a patient at HealthSource Saginaw.

This form has been fully explained to me and I certify that I understand its contents and significance.

_____	_____	_____	_____
Signature	Date	Witness	Date

_____
Relationship if other than patient

A patient representative is an individual appointed by a patient/resident, as per Section 333.21703 of the Michigan Public Health Code to participate in the planning of the patient's or resident's care and treatment but who does not have the authority to make medical treatment decisions or to refuse treatment

Patient Representative _____

Reason, if not named _____

CONTINUATION OF CARE RELEASE OF INFORMATION

Name _____ _____
And _____ Initials
Address _____

Name _____ _____
And _____ Initials
Address _____

Name _____ _____
And _____ Initials
Address _____

Name _____ _____
And _____ Initials
Address _____