GENERAL CONSENT

Consent for Treatment
I consent to and authorize the physicians, nurses and other health care providers at Children's Minnesota (Children's) to perform appropriate health care examinations, treatment, diagnostic testing, transfers and transportations deemed medically necessary by their professional judgment. I know there are risks with all medical treatment and procedures and I understand no one can guarantee how well treatments or procedures will work. Children's is a teaching hospital. In addition to my attending provider, nurses, and other healthcare providers, I will receive care from people who are in training. They are supervised by licensed health care providers and doctors. While Children's provides a wide variety of medical services, some of the care providers might not be Children's employees. If I have any questions about whether a care provider is a Children's employee, I will ask. I also understand that while Children's may recommend certain providers, the decision about who will provide care is ultimately left to me.

Consent for Use and Disclosure of Patient Information
I consent to the disclosure of my health information by Children's for treatment, payment, health care operations, purposes described in Children's Notice of Privacy Practices and as permitted or required by law. These disclosures may be made to certain individuals involved in my care, external providers, health plans and insurance companies, e-prescribing services and pharmacies, and business associates of these organizations. Children's may take photos and/or videos during your medical care and these photos/videos may be used in your medical care, process improvement, and medical education. Additionally, I consent to and authorize my non-Children's health care providers and insurance company to share my health information for the purposes stated above with Children's or to a clinically integrated network or accountable care organization in which Children's Minnesota participates.

Release of Information for Research Purposes
I consent to and authorize the release of my health information for medical and scientific research purposes. A refusal to release medical record information for research purposes is indicated by placing an "X" through this paragraph.

Assignment of Benefits/Payment for Services
I authorize and request payment of authorized benefits directly to Children's for services furnished to me at this facility or any other facility owned or operated by Children's, including physician services. I know that I must pay any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Children's to get payment for my care. This includes clearing up my disputes about charges. If I am eligible for payment from more than one type of coverage, Children's will return any extra payments to the payor. If I have an unpaid bill at Children's, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will receive a refund.

Patient Rights and Privacy Practices
You and your family's rights and our privacy practices are posted in main areas within Children's. Your signature acknowledges you have received our Notice of Privacy Practices.

Medicare/Tricare Information
Where applicable, I acknowledge receipt of materials: ☐ Message from Medicare ☐ Message from Tricare

My signature here means I have read this information and understand it. The consent to treat is valid for one year from the date of signature. All other authorizations contained in this consent are valid until revoked in writing.

Patient Name: _____ Date: _____

Guardian Signature: _____ Print Guardian Name: _____

Relationship to Patient: _____ Name of Interpreter (if used): _____

Telephone consent obtained by (name/date/title): _____

CONSWAIV

PLACE PATIENT LABEL HERE