

**Heritage Valley Health System**  
**General Consent and Release Form**

**1. CONSENT TO TREATMENT**

**This consent cannot be modified. Any handwritten changes to the form shall not be legally binding or enforceable.**

I, \_\_\_\_\_ (print or type name) on behalf of \_\_\_\_\_ (patient name and relationship) consent to the provision of treatment that may include diagnostic procedures, medical treatment and/or admission to Heritage Valley Health System (HVHS) facilities, which my physician or his/her authorized agent may consider necessary or advisable. I understand special consent forms may need to be signed for specific procedures. If I have a religious objection to specific care to be provided I may refuse such care.

I understand that my care may include examinations, diagnostic tests, medical treatment, taking photographs/video and making audio recordings that may be used for my care and/or by HVHS for education as well as health care operations purposes.

I understand and agree that others, under the direction of a physician, may assist or participate in providing hospital and/or medical care to me at HVHS. These people may include but are not limited to residents, fellows, and medical/nursing students.

I give HVHS and its designees permission to use my information as described in the HVHS' Notice of Privacy Practices for Protected Health Information.

If applicable, I give HVHS permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, these specimens/tissue cannot be retrieved. I understand and agree that HVHS and its designees may use such specimens/tissue as part of its educational activities.

I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

**2. RELEASE OF LIABILITY FOR VALUABLES**

I relieve HVHS of any responsibility for loss of clothing, money, valuables, dentures, glasses, or any other items that I decide to keep with me while I am a patient. I further understand that HVHS will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

**3. ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY**

I agree to the following terms related to payment for services provided by HVHS and affiliates.

I authorize HVHS to bill my insurance carrier and request such payments to be made directly to HVHS. I certify that the information I have given about my insurance coverage or other payment sources is correct.

I assign to HVHS all rights to insurance payments or benefits to which I may be entitled for services provided to me by HVHS. I authorize HVHS to act on my behalf and as my representative to request reconsideration (internal and/or external review process) by my managed care plan or utilization review entity for coverage or grievance review.

I authorize HVHS to release any medical or other information about HVHS services, or services provided by third parties, if required to obtain payment from my insurer or other payer and their agents to process payments. I also authorize HVHS to release any medical or other information required by my insurer, other payers and their agents. I also authorize HVHS to release medical or other information required by my insurer, other payers and their agents, government agencies or their designees for review of the care provided to me.

I assign all rights to benefits, insurance proceeds or other payments or judgments to which I may be entitled for hospital-based physician services (pathology, radiology, neurology, cardiology, anesthesiology, etc.) and/or emergency room services to the physician or organization providing the service. I also authorize submission of a claim for payment on my behalf to my insurance carrier.

I understand that any amounts not paid by my insurance are my responsibility.

If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payer regarding those services, I understand that a separate financial agreement will be put into place regarding the self-pay services and this section will not apply to such services.

If I make an application for Medical Assistance/Financial Assistance (or one is made on my behalf), HVHS is permitted to provide information as is necessary to determine whether I am eligible for Medical Assistance/Financial Assistance.

Place Patient Label Here

CON9116H (11/18)



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**HERITAGE VALLEY  
HEALTH SYSTEM**

**GENERAL CONSENT  
AND RELEASE FORM**

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**Medicare Certification (if applicable)**

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Service or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or entity to submit a claim to Medicare for payment to me. My signature at the end of this consent acknowledges my receipt of an important message from MEDICARE/MEDICARE HMO/TRICARE (formerly known as CHAMPUS / CHAMPVA) and does not waive any of my rights to request a review.

**Medicaid Certification (if applicable)**

I certify that the information given on this consent is true, complete, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds and that any false claims, statement, documents, or concealment of material facts, may be prosecuted under applicable federal and state laws.

**4. RECEIPT OF NOTICE OF PRIVACY PRACTICE/RELEASE OF INFORMATION**

I have been provided the HVHS Notice of Privacy Practices, which may have been provided to me during a previous visit.

\_\_\_\_\_ **Patient Initials (required)**

I consent to access by any HVHS affiliate (including HVHS hospitals, staff, physicians providing services to me and other entities and programs) to my medical or other information maintained on electronic information systems or stored in various forms at individual HVHS affiliates related to my treatment and/or services. I also consent to HVHS providing such information to my primary care/family physician(s) and others as necessary for referral, consultation, treatment and/or the provision of other treatment related healthcare services to me. However, my specific consent to release sensitive information contained in my medical record relating to AIDS, HIV, psychiatric care and/or treatment for drug and/or alcohol use will be obtained as required by law.

I understand that my information may be released if required by local, state or federal law.

**5. MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)**

I am under 18 years of age and for the following reason(s) GRADUATE OF HIGH SCHOOL    AM/HAVE BEEN MARRIED    AM/HAVE BEEN PREGNANT (CIRCLE ONE)

I am entitled under Pennsylvania Law to consent to medical, dental or other health services for myself, and if applicable, for my minor children without the consent of any other person. \_\_\_\_\_ **Patient Initials (required if completing this section)**

**A. I have read this General Consent and Release Form or have had it read to me, and it has been explained to my satisfaction.**

|   |             |      |                                  |
|---|-------------|------|----------------------------------|
| Patient Signature   | Date<br>/ / | Time | Signature of HVHS Representative |
| Signature/Identify on behalf of patient/relationship Name | Date<br>/ / | Time | Signature of HVHS Representative |

**B. To Be Completed if Authorization is Obtained by Telephone:**

The above authorization has been read and explained via telephone to (Name) \_\_\_\_\_ who is (relationship to patient) \_\_\_\_\_ Telephone Authorization was given on Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_\_

|                                  |             |      |
|----------------------------------|-------------|------|
| Signature of HVHS Representative | Date<br>/ / | Time |
| Signature of HVHS Representative | Date<br>/ / | Time |

Note: If parent/legal guardian arrives in person, have him/her sign in Section A.

Place Patient Label Here



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