Truesdale Medical Center

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General Consent and Disclosure

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

GENERAL CONSENT: I give permission to Truesdale Medical Center, its designated staff, and other medical personnel providing services under their sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give injections, medications, and other treatments, and render other health services to the patient identified on this form. Behavioral Health treatment of a minor cannot be provided without consent of a legal authorized representative.

INFORMED CONSENT: In addition to the above general consent, I give permission to Truesdale Medical Center and their staff to perform a search through electronic medical records of my prescribed medications.

INFORMED UNDERSTANDING: I understand that there are certain hazards and risks connected with all forms of treatment, and that no warranty or guarantee has been made to me as to the result of cure from care and treatment provided.

RELEASE OF INFORMATION: I further understand that all Medical Records, Behavioral Health/Substance Abuse Records, and Social Service Records may be released to representatives of the United States Department of Health and Human Services and to representatives of programs or projects funded by this Department and other funding services sources for the purposes of determining contract compliance with Federal/State law and regulations.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in, and that any questions I have had about the services have been answered to my satisfaction. I further certify that I have read the Patient and Clinic Rights and Responsibilities and may request a copy of this document.

EXPIRATION: I understand that this consent is valid and remains in effect as long as I am a patient of Truesdale Medical Center, until I withdraw my consent, or until Truesdale Medical Center changes its services and asks me to complete a new consent form.

SIGNATURES: Fill blank lines with NA if not applicable.

Patient Name: _____ DOB: _____ Sex: _____

Patient Signature: _____

Person Authorized to Consent (if not patient): _____ Relationship: _____

Signature: _____ Date: _____