



1. **CONSENT TO TREATMENT/TESTING:** I hereby consent to the administration of treatment and testing as considered therapeutically necessary form condition.
2. **RELEASE OF RECORDS:** I authorize the release of medical record information (including, but not limited to information concerning drug related conditions, alcoholism, psychiatric conditions, HIV testing, AID'S diagnosis related conditions) to Mercy's agents, insurance carriers, third-party payers or to their representatives; review organization, surveyors, auditors for accreditation and reimbursement, regulatory and/or licensing purposes. I also authorize release of medical record information to the provider or agency responsible for my follow-up care, and/or health care facility that I am being transferred to from a Mercy Health Partners facility.
3. The information handbook includes important information about patient rights and responsibilities and other necessary facts and materials. Copies of fees will be issued upon request.

In consideration of admission and all facility services, the undersigned agrees to the following:

4. **ASSIGNMENT OF BENEFITS:** I hereby authorize payment directly to a Mercy Health Partners facility and/or the attending physician or their designates of all insurance benefits, otherwise payable to me.
5. **GUARANTEE OF ACCOUNT:** I unconditionally guarantee the payment in full to the facility of the total amount due them for said admission and/or facility services. I understand that I am financially responsible to the facility and/or physicians for the charges not covered by the above assignment. I am also responsible for charges even if determined by my employer or insurance company to be unnecessary in their judgement.
6. I understand that physicians who render professional services to me at Mercy are independent practitioners and are not employees or agents of the hospital. Mercy is not responsible for the acts or omissions of physicians that are not directed or controlled by Mercy. Physicians bill independently.
7. I have read and do understand this form.

Signature of Responsible Party

Date

Relationship to Patient

Witness

AUTHORIZATION TREATMENT/RELEASE OF RECORDS/ASSIGNMENTS OF BENEFITS

#16376 11/2000





My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices* (Version Effective 4-14-2003).

Signature of Patient or Legal Representative

Date _____

If signed by legal representative, relationship to patient

[To be completed if patient refuses to sign acknowledgement]

Patient was provided with a copy of the *Notice of Privacy Practices* (Version Effective 4-14-2003)

on (date) _____

by (Name of person providing the Notice) _____ .

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

