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CONSENT AND ASSIGNMENT - PAGE 1 OF 2

**Name:**

**DOB:**

**AUTHORIZATION FOR TREATMENT, RELEASE AND USE OF INFORMATION,  
PHOTOGRAPHS, VALUABLES RESPONSIBILITY, MEDICARE BENEFITS,  
ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT**

**TREATMENT:** I authorize Eskenazi Health (Hospital), and its agents and employees, and members of the Hospital's medical staff, and their agents and employees (collectively referred to as Healthcare Providers), to furnish inpatient and outpatient medical and surgical care and services, including but not limited to diagnostic tests, examinations, and other medical and surgical procedures that are deemed necessary for my health and well being. I acknowledge that no representations, warranties, or guarantees as to results or cures have been made to me by the physicians, agents, or employees of the Hospital, nor have I relied on any such representations, warranties, or guarantees.

I understand that members of the Hospital's medical staff are independent contractors, not Hospital employees, and that the medical staff is not subject to the control and supervision of the Hospital.

I understand that the Hospital is a teaching institution affiliated with Indiana University School of Medicine, and I agree that physicians in residency training and students in training to become physicians, nurses, and allied health providers may assist in providing my care. I also agree that my medical records may be used for purposes of research, education, and patient care. I further understand that any data or specimen(s) obtained from me during my care may be used in research that may or may not be related to my condition. "Specimen" includes, without limitation, any organ, tissue, bone, or other bodily part or bodily fluids of any kind. I acknowledge that I have no property or ownership interest in any specimen and no right in or entitlement to any research or research product using or derived from any specimen.

**CONSENT FOR BLOOD BORNE INFECTIOUS DISEASE TESTING:** I authorize the Hospital to test for blood-borne infectious diseases, including, but not limited to, hepatitis and human immunodeficiency virus, if ordered by a physician, in the event one of my health care providers is exposed to my blood or bodily fluid.

**RELEASE OF INFORMATION:** I authorize release of medical record information, pursuant to applicable federal and state laws, rules, and regulations, to third party payors, health care institutions, physicians and other providers who may have me as a patient, and research institutions that agree to treat my information in a confidential manner. I also authorize the use of information from my medical record for purposes of medical care, treatment, evaluation, and scientific investigation, with the understanding that, except as specifically required under federal, state, or local law, this information will be used for compiling statistics and will not identify me by name.

I further authorize any other individual or entity that has provided health care to me, which may include Indianapolis-area hospitals, health care providers, managed care organizations, laboratories, and pharmacies, to release to the Hospital any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed medical care. This authorization to release information to the Hospital extends to records relating to communicable diseases and drug and alcohol abuse treatment records protected by 42 C.F.R. Part 2. I understand that my medical record information will be kept confidential pursuant to applicable federal, state, and local laws, subject to the Hospital's obligations under applicable law. My consent for the release of this information to the Hospital may be revoked by me at any time, except to the extent that action has been taken in reliance on the consent, and subject to the Hospital's authority under applicable law. I understand this consent will be effective so long as reasonably necessary to provide care to me.

Unless otherwise specified, I authorize the release of general information, such as name, admission, and discharge, medical condition in general terms, and hospital room and hospital phone number.

**PHOTOGRAPHS:** I consent to recording and filming of my care for internal hospital use, including but not limited to photographs or recordings used for my medical record and care, performance improvement, and teaching. I understand that when a recording or film is used for external purposes, separate consent will be obtained.

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ESKENAZI HEALTH  
Indianapolis, Indiana

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CONSENT AND ASSIGNMENT - PAGE 2 OF 2

Name:

DOB:

**VALUABLES RESPONSIBILITY:** The Hospital does not assume responsibility for any valuables or personal possessions brought into the Hospital, except those placed in the vault for safekeeping. The Hospital shall not be liable for any loss or damage to property I choose to keep with me. This includes dentures, eyeglasses, and hearing aids. No employee or agent of the Hospital or member of the Hospital's medical staff has the authority to waive this rule.

**MEDICARE BENEFITS:** I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in the Hospital, including services by Healthcare Providers. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

**ASSIGNMENT OF BENEFITS:** I hereby assign, transfer, and convey to the Hospital and any Healthcare Providers all hospital, medical, surgical and related benefits, including major medical benefits, payable under any insurance policies, such amounts to be applied to my Hospital or Healthcare Provider accounts.

**GUARANTEE OF PAYMENT:** In consideration of the furnishing of medical, hospital, and related services to the patient by the Hospital and Healthcare Providers, I hereby guarantee payment in full of my account in accordance with the financial arrangements made at the time of discharge. If no arrangements are made, then payment shall be made in full within thirty (30) days of discharge. In addition, if a claim for damages arises as a result of the injuries for which I am being treated, I authorize my attorney/agent to pay all unpaid medical bills owed to the Hospital related to the injuries out of any proceeds that I receive from any third party. Payment of such medical bills shall be paid before any monies are paid to me personally. I also agree to maintain my account current until settlement is reached. The undersigned agrees that in the event of default in payment, this document shall be construed as a written contract for the payment of services and that reasonable attorneys fees, allowable interest, and reasonable cost of collection may be added to the amount due on the account.

**ADVANCED DIRECTIVE:** I acknowledge that I have received an Eskenazi Health *Patient Handbook* with the Advanced Directive Information.

**NOTICE OF PRIVACY PRACTICES:** I acknowledge I was offered a copy of the Eskenazi Health *Notice of Privacy Practices*.

\_\_\_\_\_  
Hospital Witness

\_\_\_\_\_  
Patient's (or responsible person's) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**STAFF  
USE  
ONLY:**

Patient unable to sign

\_\_\_\_\_  
Staff Initials      Reason

Patient refused

\_\_\_\_\_  
Staff Initials



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