Children's Hospital of Pittsburgh of UPMC

CONSENT FOR TREATMENT AND HEALTH CARE OPERATIONS; RONALD McDONALD CARE MOBILE

Form CHP.0394 12/08

DATE / /

Patient Name

Medical Record Number

Birthdate

CHILDREN'S HOSPITAL OF PITTSBURGH (CHP)/UNIVERSITY OF PITTSBURGH MEDICAL CENTER (UPMC) CONSENT FOR TREATMENT AND HEALTH CARE OPERATIONS (TO)

CONSENT TO MEDICAL CARE

1. I,____ **(print or type name)** consent to the provisions of care that may include diagnostic procedures, medical treatment and/or admission to the CHP/UPMC, which my/my child's attending physician or his/her authorized agent may consider necessary or advisable. I understand special consent forms may need to be signed for procedures involving entry into my/my child's body. If I have a religious objection to specific care to be provided I may ask CHP/UPMC not to provide such care.
2. I understand that my/my child's care may include examinations, diagnostic tests, medical treatment, taking photographs/video and making audio recordings that may be used for my/my child's care and/or by CHP/UPMC for education.
3. 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/my child at CHP/UPMC teaching facilities. These people may include but not limited to residents, fellows, and medical/nursing students.
4. I give CHP/UPMC and its designees permission to use my/my child's medical information as described in the CHP/UPMC *Notice of Privacy Practices*.
5. If applicable, I give CHP/UPMC permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my/my child's body. Once disposed of these specimens/tissue cannot be retrieved. I understand and agree that CHP/UPMC and its designees may use such specimens/tissue as part of its educational activities. I understand and agree that CHP/UPMC and its designees may use such specimens/tissue as part of its educational activities. I understand that state and federal law allows CHP/UPMC to use specimens/tissue for research purposes without my/my child's authorization if my/my child's identity is not linked to the specimens/tissue. I will be asked to provide authorization for use of my/my child's specimens/tissue in research if my/my child's identity is linked to the specimens/tissue.
6. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment. Results of any examination and/or treatment are kept confidential.

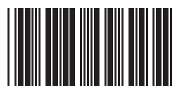
I have read this Consent to Medical Care section or have had it read to me, and it has been explained to my satisfaction.
[Verbal consent by the parent/guardian/patient requires two witness signatures below.]

Patient Signature	Date	Signature of CHP/UPMC Representative
Signature/Identity on behalf of patient	Date	Signature of CHP/UPMC Representative
Relationship to patient		

RELEASE OF INFORMATION

I agree to the following terms related to release of information for services provided by CHP/UPMC and affiliates. Information related to mental health and drug and alcohol treatment requires specific consent – see number 5 below.

1. I authorize CHP/UPMC to release medical or other information required by my/my child's insurer, other payors and their agents, government agencies or their designees for review of the care provided to me/my child.
2. I have been provided the *CHP/UPMC Notice of Privacy Practices*. I also understand that additional copies of this Notice are available for my/my child's review upon request. ____________________ **Parent/Guardian/Patient initials (required)**
3. I consent to access by any CHP/UPMC affiliate (including CHP/UPMC hospitals, staff, physicians providing services to me/my child and other entities and programs) to medical or other information maintained on electronic information systems or stored in various forms at individual CHP/UPMC affiliates related to treatment and/or services provided to me/my child by CHP/UPMC or any affiliate in connection with my/my child's care, health care operations or payment for treatment and services. I also authorize information related to my/my child's care to be provided to my/my child's primary care/family physician(s) and as otherwise necessary for referrals, consultation, treatment and/or other treatment related health care services to me/my child.
4. I understand that my/my child's information may be released if required by local, state or federal law.
5. **For Mental Health and Drug and Alcohol Patients Only.** I authorize the release of my/my child's mental health and/or drug and alcohol treatment information to government agencies or their designees for review of the care provided. Additionally, with respect to any drug and alcohol related information, disclosure of such information about me/my child shall be restricted to whether or not I/my child am/is in treatment, my/child prognosis, the program structure treatment model and services offered to me/my child, a brief description of my/child progress and a short statement as to whether I/my child have/has relapsed into drug and alcohol abuse and the frequency of any such



relapses and other information permitted under 4 Pa. Code Section 255.5(b). I understand that I have the right to revoke this permission at any time by notifying the CHP/UPMC entity where I had provided such permission.

______________________________ **Parent/Guardian/Patient Signature (required if applicable)**

MEDICARE CERTIFICATION (IF APPLICABLE)

I certify that the information given to me/my child 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/my child to release to the Centers for Medicare and Medicaid Services or its intermediaries or carriers, andy information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my/my child's 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 child.

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. Acknowledgment of receipt - my/my child's signature acknowledges my/my child's receipt of an important message from MEDICARE/MEDICARE HMO/TRICARE (formerly known as CHAMPUS / CHAMPVA) and does not waive any of my/child's rights to request a review.

PATIENT VALUABLES

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

AGREEMENT TO MEDIATE CLAIMS

By initialing below, I agree that any claim which may result from the care provided to me/my child by the doctors, nurses and other health care providers in any CHP/UPMC facility shall be subject to the laws of Pennsylvania. I also agree that before any lawsuit is filed related to the care provided to me/my child, I must attempt to resolve any claim through mediation, which must take place in the Commonwealth of Pennsylvania. I am not waiving my/my child's right to a jury trial. Mediation is a process in which a neutral third person tries to help settle a claim. This agreement is binding on me/my child and any person making a claim on my/my child's behalf.
Parent/Guardian/Patient Initials:______________(optional)

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s) ______________________________

______________________________, 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)**

I have read this Release of Information section or have had it read to me, and it has been explained to my satisfaction.

Patient Signature	Date	Signature of CHP/UPMC Representative
Signature/Identity on behalf of patient/relationship Name	Date	Signature of CHP/UPMC Representative

FOR OFFICE USE ONLY

Patient Name______________________ Account Number______________ MR Number ______________

Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices ______________________________

Reason given by patient for failure to acknowledge receipt of the Notice of Privacy Practices ______________________

☐ Previously Received ☐ Refused ☐ Other: ______________________________

If parent/guardian is not with patient at time of registration:

I acknowledge that CHP/UPMC provided to me a Notice of Privacy Practices and Consent form for me to deliver to the parent/guardian of the child listed above on ______________ (date)

Signature:______________________________

Name: ______________________________ (print) Relationship to Minor: ______________________