



- St. Joseph Mercy Hospital
- St. Joseph Mercy Livingston Hospital
- St. Joseph Mercy Saline Hospital
- St. Joseph Mercy Woodland Health Center

Outpatient Consent and Authorization

I. Consent for Medical Treatment

I, _____ freely consent to admission to such care and treatment as my physician considers necessary. I authorize the performance of diagnostic tests, including lab tests and x-rays, and such other medical and surgical procedures as are recommended by my physician.

II. Authorization for Release of Medical Records

I authorize Saint Joseph Mercy Health System and any other holder of medical information about me, to release information contained in my medical records to the party responsible for payment for my care, including but not limited to the Medicare/Medicaid programs, my insurance carrier, my employer's insurance carrier, and/or any other party, including a family member or other individual, whom I have indicated will be responsible for payment for my care. I intend that this consent for the release of medical information to these parties shall extend to any information concerning HIV infection, AIDS or AIDS Related Complex. This authorization is effective for as long as necessary to obtain reimbursement. It will end when the hospital and my physician(s) obtain full reimbursement from all sources or when revoked by me in writing.

III. Authorization for Payment of Insurance Benefits

I authorize payment of insurance benefits (including Medicare/Medicaid benefits) to be made directly to Saint Joseph Mercy Health System and my attending physician(s). I understand that I am financially responsible to Saint Joseph Mercy Health System and attending physicians for services not covered or payable by my insurance carrier. I further understand that Saint Joseph Mercy Health System is under no duty or obligation to seek payment from an insurance carrier before requesting full or partial payment from me. This authorization shall remain effective until revoked by me in writing.

I intend that my consent to the above matters shall remain valid for a period of six (6) months from today's date and shall apply to all outpatient services received by me from Saint Joseph Mercy Health System during that time period.

IV. Agreement of Spouse to be Financially Responsible

I, _____, spouse of _____ agree, in addition to my spouse, to be responsible for payment for all medical services rendered to my spouse.

I/we have read and understand the contents of this form.

I/we understand that I/we should ask questions that I/we have regarding this form before I/we sign it.

Signature of Patient

Date

Signature of Patient's Spouse

Date

Signature of Witness

Date

Patient unable to sign because of _____

Signature of Substitute Decision Maker

Date

Relationship to Patient

Date