

## AUTHORIZATION AND RELEASES Copy of Document

## **AUTHORIZATIONS AND RELEASES**

- 1) Authorization for Treatment: I hereby authorize and consent to the administration and performance of all treatments (during this hospitalization or on an outpatient basis including emergency treatment or services, and which may include, but are not limited to, laboratory procedures, x-ray/radiologist examination, medical treatment, hospital services or home care rendered for the patient) by the physician in charge of the above-named patient, or other physicians of the hospital's medical staff considered to be necessary or advisable. Further, I realize that among those who attend patients in this hospital are medical, nursing, and other health care personnel in training who, unless requested otherwise, may be present during patient care as part of their educational process and will be supervised.
- 2) Consent for Emergency Treatment: If I believe that I am suffering from an emergency medical condition, I know this condition entitles me to an appropriate medical screening and treatment necessary to stabilize my condition. I therefore authorize the Hospital to provide an appropriate medical screening evaluation and treatment, to be performed by or under the supervision of a physician or his/her aide. It has been explained to me that the diagnostic treatment procedures, which my emergency medical condition legally entitles me, are limited and will include a medical screening examination. If may be necessary for me to select another physician and obtain from him/her a complete diagnosis of my condition and such continued treatment as he/she may prescribe.

3)	Authorization	for	Release	of	Medical	Information:
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	Jamestown Regional Medical Center is authorized to release medical information to the primary care physician and any other physician(s) responsible for follow-up care.
	Jamestown Regional Medical Center is authorized to release or obtain information necessary to determine benefits, conduct Utilization Review, and file the claim to the insurance company(s) that I have disclosed. Medical records may be released by H.I.M. at the request of the insurance company in order to process and provide reimbursement for the account.
	Medicare and ND Medicaid records are subject to review by NDHCRI with review results directed to the hospital/physician and/o the patient.
	Jamestown Regional Medical Center is authorized to release medical information to accrediting and surveying bodies.
	Jamestown Regional Medical Center is authorized to release medical information, provided all identifiable data is removed prior to review, for purposes of the evaluation of health care personnel in training.
	I acknowledge that patient medical records at the Hospital may be stored electronically and made available through computer networks to Hospital personnel, as well as physicians involved in my care and their offices. This will assist my physician and other caregivers in reviewing past treatment as it may affect my condition and treatment at that time.
	I authorize the release of my social security number in accordance with federal law and regulation to the manufacturer of any medical device I may receive.
4)	Medicare - Patient's Certification, Authorization to Release Information and Payment: I certify that the information
	given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of
	medical or other information about me to release to the Social Security Administration and/or the Medicare
	Program or intermediaries or carriers or to the Professional Standards Review Organization any information needed
	for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

- directly to my health insurance carrier or other health benefit plan for the services the Hospital and/or hospital-based physician to be paid directly to my health insurance carrier or other health benefit plan for the services the Hospital and/or hospital-based physician provide to me, my minor child, or other person entitled to health care benefits for this admission. In return for the services rendered and to be rendered by the Hospital and/or hospital based physicians, I hereby irrevocably assign and transfer to the Hospital and/or hospital based physicians all rights, title and interest in all benefits payable for the health care rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting the Hospital and/or hospital base physicians an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of the Hospital and/or hospital based physicians to pursue any such right of recovery. I have read and been given the opportunity to ask questions about this agreement of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the Hospital and hospital based physicians. I understand that I may receive separate bills for various physician charges, including Radiology, Pathology, and/or Emergency Room Service.
- **6) Financial Agreement:** If I am the patient, or an individual legally obligated to pay for medical services for the patient, I hereby agree to pay Jamestown Regional Medical Center and any physician participating in the



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treatment and care for any and all services rendered to the patient. I understand any contract or agreement between the patient and a third party to transfer financial responsibility does not involve Jamestown Regional Medical Center or change my obligation to pay. I hereby acknowledge financial responsibility for any and services rendered which the insurance plan may exclude from payment, either because the plan deems such services not medically necessary, or for any other reason, including pre-certification requirements, second opinions, or pre-existing conditions. I shall hereby be responsible for payment in the event the insurance plan does not pay within the hospital payment terms.

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71	the hospital payment		roburologia lamasta	was Dagianal Madical Center from all respons	ihilit.
<b>7)</b>	relative to the loss and time of admission; this hospital does not assusafekeeping; this inclube left at or sent home explosive device, illeging Hospital may confisce delivery of any item to the No: Lock with the Lock with the Lock with the loss and th	d/or damage to mon includes any articles me responsibility for pades dentures, glassese. I understand and cal substance or drugate any of the above of law enforcement are aluables in safe	ey, valuables, and/o the patient may according possessions s, hearing aids, prosthagree that if the Hosp , or any alcoholic be items that are found uthorities.	own Regional Medical Center from all responser property, which are not placed in the vault of quire during this period of care. I understand the that are not declared and placed in the vault deses, etc. It is highly recommended that value ital at any time believes there may be a weat werage in my room or with my belongings, the and dispose of them as appropriate, including ient Responsible for valuables lerstand that while I am a patient at the Hospiles	at the nat the t for ables pon, e
٠,	may not use tobacco		300 1100 14011117.1 0110	ioristaria irrat Willio Farri a palietir ar irre riespi	1011
9)			Opt Out of the Facility	Directory: The Hospital will not divulge any	
-	identifying information information about you	n about patients with or presence in the Ho	out their consent. Wit spital during your sta	h this in mind, we need your permission to rele y. By choosing to opt out of the Facility Directo u will not receive flowers, cards, phone calls, c	ory,
		se to opt out of the	☐ Yes lag	gree to be on the Facility Directory.	
10)		y Directory	00	on patient, Clergy may be informed of my star	, at
10)	Jamestown Regional	• ,	palierii oi Observalio	on patient, clergy may be informed of my sta-	/ ui
		1			
11\			omination:	ome care patient, I have received Advanced	1
11)				ccountabilities information.	1
12)	VA: No	Yes	Talletti Rigitis aria A	ecconnabilines in formation.	
_	Injury: No	Yes			
,	Date: MVA	Other V	VC WC Filed		
14)	HH/Hospice: No	Yes			
15)	hereby certify and sto	te that I have read, ave signed these Aut	and that I fully and co horizations and Relea	ation and Release form is as valid as the origin ompletely understand the above Authorization ases knowingly, freely, and voluntarily. The ent's representative.	
	Signature of Patient or prized Representative:			Date:	
iı	If other than patient, ndicated relationship:				
Reas	on patient unable to si	gn: 🗆 Unconscious	□ Incoherent	□ Unable to Transact Business	
		□ Minor	□ In Great Pain	□ Other	
	Sianature of Witness:			Date:	