Children's MINNESOTA

General Consent

PATIENT CONSENT
To our patients and families: We are required to explain your rights and responsibilities while a patient at Children's Hospitals and Clinics of Minnesota and its affiliates (collectively, "Children's"). If you have questions concerning your rights or Children's privacy practices, please ask your care provider or contact Children's Privacy Officer at (612) 813-6911 or e-mail: privacy.officer@childrensmn.org.

Consent for Treatment
I consent to and authorize the physicians, nurses and other healthcare providers at Children's to perform appropriate healthcare examinations, treatment, diagnostic testing, transfers and transportation as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatment and procedures and I understand that no one can guarantee how well treatments or procedures will work. Children's is a teaching hospital. In addition to my attending provider, nurses, and other healthcare providers, I will receive care from people who are in training. They are supervised by licensed health care providers and doctors.

Release of Information for Treatment, Payment and Health Care Operations
I consent to and authorize Children's to use and disclose my protected health information for treatment, payment and health care operation purposes, including care coordination and quality assessment and improvement activities. Releases for these purposes may be made to my primary care provider and consultants who are being advised or consulted in connection with my treatment, e-prescribing services, record locator services, insurance companies, health plans, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and other healthcare providers involved in my care and treatment. Additionally, I consent to and authorize my insurance company to share my protected health information for the purposes stated above to a clinically integrated network or accountable care organization in which Children's participates.

Release of Information for Research Purposes
I consent to and authorize the release of medical record information for medical and scientific research purposes. ***A refusal to release medical record information for research purposes is indicated by placing an "X" through this paragraph.***

For NICU Transports only: I also consent to the sharing of information on my baby's diagnosis and condition with the nurses and physicians at_____(name of hospital).

Assignment of Benefits/Payment for Services
I authorize and request payment of authorized benefits directly to Children's for services furnished to me at this facility or any other facility owned or operated by Children's, including physician services. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Children's to get payment for my care. This includes clearing up any disputes about charges. If I am eligible for payment from more than one type of coverage, Children's will return any extra payments to the payor. If I have an unpaid bill at Children's, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will receive a refund.

Patient Rights and Privacy Practices
You and your family's rights and our privacy practices are posted in main areas within Children's. Your signature acknowledges you have received our Notice of Privacy Practices.

Medicare/TriCare Information
Where applicable, I acknowledge receipt of materials: □ Message from Medicare □ Message from TriCare

My signature here means I have read this information and understand it. The consent to treat is valid for one year from the date of signature. All other authorizations contained in this consent are valid until revoked in writing.

Patient Name:_____ **Date:**_____

Guardian Signature:_____ **Print Guardian Name:**_____

Relationship to Patient:_____ **Name of Interpreter (if used):**_____

Telephone consent obtained by (Name/Date/Title):_____

CONSWAIV