ST. JOSEPH MERCY OAKLAND
SAINT JOSEPH MERCY HEALTH SYSTEM

PHYSICIAN CONSENT FORM

The undersigned consents to the rendering of medical care pursuant to the following terms:

1. I understand that my physician is part of the St. Joseph Mercy Oakland ("SJMO") Physician Network and I agree that my physician and other SJMO healthcare providers may render such medical treatment, including diagnostic procedures, lab tests and x-rays, as they deem necessary.

2. I understand that I have the right to consent, or to refuse any proposed procedure or therapeutic course.

3. I understand that: SJMO is a teaching hospital and that medical students, who may be doctors, nurses or other allied health students may assist in my treatment at a SMJO physician office.

4. I specifically authorize release of my patient records, including: alcohol and drug abuse records protected Code 42 of Federal Regulations, Part 2, psychological services records; social services records, including communications made by me to a social worker or psychologist; records of HIV testing including results, records of treatment for AIDS; and records of a communicable disease to (a) my insurance company for the purpose of payment of the bill; and/or (b) to another health care provider for the purpose of transferring care to other health care provider.

5. I understand that if a healthcare provider at my physician's office sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound exposure to my blood or other bodily fluids I may be tested for HIV which causes AIDS.

6. I hereby release SJMO from responsibility for all personal articles, which I have with me at the time of my office visit.

7. I agree to the release of my medical information to my insurance company(s) and further assign and authorize payment from my insurance company directly to SJMO for all services provided. I understand that I am financially responsible to SJMO for services not covered or payable by my insurance company irrespective of any dispute between my insurance company and myself.

8. I ___ agree or ____ object to the sharing of information regarding my medical care or treatment with family members and other relatives.

9. In the event of a disaster, I ___ agree or ___ object to the sharing of my location, condition, or death to agencies assisting with disaster relief efforts for the purposes of notifying my family.

10. I am the parent/spouse of _____ (Names of spouse/children) and I understand that in addition to my spouse, I am responsible for payment for any medical services rendered to my spouse/child.

11. I acknowledge that I have received SJMO's Notice of Privacy Practices. _____
Patient Signature Required

This consent form has been fully explained to me and I understand its contents and the consents made by me.

_____	_____	_____	_____
Signature of Patient	Date	Witness of Patient Signature	Date

If the patient is unable to consent or is a minor under eighteen (18) years of age, complete the following.

_____	_____	_____	_____
Signature of Patient	Signature of Authorized Person	Relationship to Patient	Date