Beth Israel Lahey Health Exeter Hospital

Beth Israel Lahey Health Core Physicians

PATIENT ID OR LABEL

**Patient's Printed Name: _____ Date of Birth: _____**

**GENERAL CONSENT FOR OUTPATIENT DIAGNOSIS, CARE, AND TREATMENT:**

On an ongoing basis, I request, consent, and authorize Core Physicians, LLC (Core) and Exeter Hospital, Inc. (EH) to perform diagnostic and therapeutic tests and procedures and provide general care and treatment as determined necessary and/or ordered by those healthcare professionals involved in my care. This includes, but is not limited to, the performance of physical examinations and x-rays or other radiographic procedures, as well as the taking of blood, tissues, fluids, or other bodily samples. I also consent and authorize Core and EH to examine, use for the purposes for which they were provided, store, and dispose of any blood, tissue, fluids, or other bodily samples in accordance with legal requirements and customary procedures. I understand I may ask my healthcare providers about my care, treatment and procedures at any time and I am encouraged to do so.

I understand most members of EH's medical staff are neither employees nor acting on behalf of or as agents of EH and will bill separately for their services. I also understand healthcare professionals in training may be involved in my care and I consent to their involvement in it under appropriate supervision. For Core care, I further I understand that the Providers and staff are employees of Core Physicians, LLC.

**FINANCIAL RESPONSIBILITY AGREEMENT AND ASSIGNMENT OF BENEFITS:**

I understand I am financially responsible for all of the charges and bills associated with my care and treatment, except to the extent that all or part of these charges or bills are paid or covered by health insurance, a government healthcare program (such as Medicare or Medicaid), a financial assistance program, or another party responsible for their payment (all of which are referred to as "Third Party Payers"). I authorize Core and EH to submit bills or claims and related information concerning my health status, care, treatment, and payments made for my care and treatment to any applicable Third Party Payer and its business associates. I also authorize such Third Party Payers to make payments directly to Core and EH in response to these bills or claims.

**CONSENT AND AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION:**

Core and EH maintain health records in electronic and other forms. These records describe, among other things, my past and current health status, including the diagnoses of any illnesses and conditions, the nature and results of examinations and tests, treatment provided, and any plans for care or treatment. In addition, these records include billing, social, and other identifying information and may include sensitive information such as genetic testing results, HIV/AIDS status, and drug or alcohol use (all of which is referred to as my "Health Information"). I consent and authorize Core and EH, when necessary for my treatment, payment of my bills, or Core's or EH's business operations, to release and exchange my Health Information between the affiliates. I also consent and authorize Core and EH and their affiliated organizations to release and exchange my Health Information with other healthcare professionals and organizations involved in my care and with business associates that Core, EH or their affiliated organizations have contracted for the same reasons.

**QUESTIONS ABOUT THIS CONSENT FORM HAVE BEEN ANSWERED.**

**I UNDERSTAND THE INFORMATION IN THIS FORM AND AGREE TO THE CONDITIONS SET FORTH ABOVE. THIS CONSENT SHALL REMAIN EFFECTIVE UNTIL I REVOKE IT IN WRITING, WHICH I MAY DO AT ANY TIME.**

Signed: _____ Date: _____
(Patient or Authorized Representative)

Printed Name: _____

Relationship of Authorized Representative: _____
(For example, Legal Guardian, or Healthcare Agent)