ST. JOSEPH MERCY OAKLAND
A MEMBER OF TRINITY HEALTH

CONSENT AND REQUEST FOR CARE & SERVICE – SJMO

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

1. SJMO health care providers may render such medical treatment, as they deem necessary, including diagnostic procedures, lab tests and x-rays.
2. I understand that there may be a need to give blood or blood products unexpectedly. In the event I am unable to give consent, such as in an emergency situation, I consent to receive transfusions of blood and/or blood products. I acknowledge that there are benefits and risks of transfusion, as well as medical alternatives. Risks include but are not limited to: fever, allergic reactions, destruction of transfused cells, transmission of diseases such as hepatitis, AIDS and other blood-borne diseases, or fluid overload. Reactions could be minor to life threatening.
3. I recognize that the practice of medicine is not an exact science. No agent or representative of SJMO has made any representation, guarantee, or warranty to me regarding the results of any treatment or examination.
4. I understand that:
   a) It is customary, absent emergency or extraordinary circumstances, that no substantial procedures are performed unless the patient has had an opportunity to discuss them with the physician or other health professional.
   b) Each patient has the right to consent, or to refuse any proposed procedure or therapeutic course; and
   c) No patient will be involved in research or experimental procedure without his/her knowledge and consent.
5. If I am hospitalized for the delivery of my infant, I am consenting to the treatment of my infant and myself.
6. I understand that this is a teaching facility and resident doctors, nursing and allied health students may assist in aspects of my care. I also understand that many physicians are not employees or agents of the hospital but rather, are members of the medical staff who have been granted the privileges.
7. I authorize release of my patient records, including: alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; psychological services records; social services records, including communications made by me to a social worker or psychologist; records of HIV testing including results, if any; records of treatment for AIDS; and records of a communicable disease to my insurance company for the purpose of payment of the bill or to another health care provider for the purpose of my transfer to such other health care provider.
8. I understand that if an employee, physician, or agent of the hospital 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.
9. I hereby release SJMO from responsibility for all personal articles, which I have with me during my admission. I understand that SJMO is not responsible for clothing, eyeglasses, dentures, jewelry, money or other personal articles of value kept in my possession or in my room.
10. 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. If I am a Medicare beneficiary admitted as an inpatient, I acknowledge receipt of a form called "*An Important Message From Medicare*."
11. I ___ agree or ____ object to the inclusion of my name and other identifying information in the SJMO Patient Location Listing.
12. I ___ agree or ____ object to the sharing of information regarding my medical care or treatment with family members and other relatives.
13. 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.
14. 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/Time	Witness of Patient Signature	Date/Time

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/Time