Western OB/GYN
A Division of Ridgeview Clinics

PATIENT CONSENT

Label

Instructions: Please initial each category you consent to, sign and date below.
Please let us know if you have any questions or if you need a language interpreter.

Agreements: I am asking for services from Ridgeview Clinics. I agree to the following:

____ **Authorization as for Care:** I authorize Ridgeview Clinic, its employees, agents and any physicians caring for me to provide treatment that is mutually agreed upon, between myself and my care team, as most beneficial for me.

____ **Insurance Consent:** I request that payment of authorized benefits be made to the Clinic on my behalf for all services furnished to me, including physician services. I authorize any holder of medical or other information about me to release to the Clinic, Medicare and its agents, any insurance company, any third-party payor, state medical agency, or any other governmental or private payor responsible for consideration of services rendered. I agree to pay the Clinic for all charges not covered by any third-party payor.

____ **Health Information / Consent to Use and Disclose Health Records:** Ridgeview Clinic is fully committed to safeguarding the privacy and legal rights of its patients. These rights include the use and release of protected health information outlined, in full, in the Clinic's Notice of Privacy Practices.

I acknowledge that I have received Ridgeview's Notice of Privacy Practices, explaining how my personal health information is used and understand my individual rights related to that information.

By signing and dating this document, I hereby consent to the use and disclosure of my health information and my health records, 1) described in the Notice of Privacy Practices including, but not limited to treatment, payment and healthcare operations, or 2) otherwise allowed by federal law without my written authorization.

____ **I Authorize** my insurer, health plan, or claims administrator and Ridgeview Medical Center to share with each other my health information and health records for care coordination and quality improvement purposes. This includes sharing my health information and health records from treatment I have received at health care providers not related to Ridgeview Medical Center. My insurer, health plan or claims administrator may also share the above information and records with a care system or accountable care organization in which Ridgeview Medical Center participates.

If I do not want my health information or health records shared for these purposes, I may opt out by initialing the statement below:

____ I do not authorize my insurer, health plan or claims administrator and Ridgeview Medical Center to share my health information and health records as described above.

____ **Authorization as to Body Fluids:** I understand that while at the Clinic, a healthcare worker may accidentally be exposed to my blood or body fluids. If this occurs, I authorize the Clinic, its agents or employees, and any physicians caring for me, to remove a blood sample from me to test for infectious agents such as HIV or Hepatitis. There will be no charge to me for this testing. I acknowledge these tests will become part of my personal medical record and that the Clinic is required to confidentially report all positive test results to the Minnesota State Board of Health.

____ **Medications:** I agree that you may e-prescribe my prescriptions, and may request and use my prescription history from other healthcare or third party pharmacy benefit payers for treatment purposes.

I ACKNOWLEDGE I HAVE READ AND AGREE TO THE ABOVE.

_____ _____
(Patient's Signature) *(Date & Time)*

_____ _____
(Parent or Guardian Signature - If Minor) *(Date & Time)*

*** * This agreement will expire 1 year from the date of signature * ***

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____ **Authorization as to Body Fluids:** I understand that while at the Clinic, a healthcare worker may accidentally be exposed to my blood or body fluids. If this occurs, I authorize the Clinic, its agents or employees, and any physicians caring for me, to remove a blood sample from me to test for infectious agents such as HIV or Hepatitis. There will be no charge to me for this testing. I acknowledge these tests will become part of my personal medical record and that the Clinic is required to confidentially report all positive test results to the Minnesota State Board of Health.

____ **Research:** I authorize the release of my information to Ridgeview Research.

____ **Medications:** I agree that you may e-prescribe my prescriptions, and may request and use my prescription history from other healthcare or third party pharmacy benefit payers for treatment purposes.

I ACKNOWLEDGE I HAVE READ AND AGREE TO THE ABOVE.

_____ _____
(Patient's Signature) *(Date & Time)*

_____ _____
(Parent or Guardian Signature - If Minor) *(Date & Time)*

*** * This agreement will expire 1 year from the date of signature * ***

Western OB/GYN
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Medical Authorization for Minors

Label

This will authorize Ridgeview Clinics to provide Medical Care for the above patient.

I understand that I may revoke this request at any time.
This consent will automatically expire 1 year from the signed date.

Signature of Parent or Guardian: _____

Relationship to above patient: _____

Date (verbal or written): _____

Written Consent requires the signature of one witness.

Signature of Witness: _____

Date Written Consent Given: _____

Verbal Consent must be given to two staff members of Ridgeview Clinics. The following two employees received verbal consent to treat the above patient.

1st Employee's Signature: _____

2nd Employee's Signature: _____

Date Verbal Consent Given: _____

Reason patient is unable to sign: Minor

This Medical Authorization will expire on: _____
(1 year from the date listed above)