St. Elizabeth Healthcare
Covington/Edgewood/Grant Co., Kentucky

Patient:_____

Acct. No.:_____ Date:_____/_____/_____

MEDICAL AUTHORIZATION AND RELEASE

Authorization must be signed by the patient if age 18 or over or by a minor patient (under 18) if emancipated or otherwise eligible pursuant to KRS 214.185 (See Consent Procedure); or by the parent or legal guardian for any other minor; or by the patient's legally authorized representative if the patient is otherwise unable to consent (See Consent Procedure).

1. I, the undersigned, a patient of St. Elizabeth Medical Center (SEMC) do hereby and herewith freely and voluntarily agree and consent to and authorize the administration and performance of all medical treatment and medical operations, the administration of any medically accepted anesthetic, the use of any lawful kind of drugs, and the use of any medically accepted diagnostic procedures, which in the professional medical judgment of my physician, may be considered medically necessary, advisable, or otherwise appropriate. If I am admitted for pregnancy or childbirth, I further authorize the performance of a toxicology test (i.e., drug screen) if ordered by my physician to determine whether alcohol or drugs were ingested during pregnancy. The purpose is to clarify potential for or possibility of fetal exposure to alcohol or drugs.

2. I further authorize and consent to the taking of cultures and blood samples and the performance of medically accepted laboratory tests for human immunodeficiency virus, hepatitis or any other blood-borne infectious disease upon the order of a physician for diagnostic purpose or in the event a physician, health-care worker or SEMC employee is exposed to my blood or body fluids in the course of my treatment at or transportation to SEMC. I further authorize SEMC to take such precautions as are deemed necessary for my safety and the safety of others in infectious cases.

3. I understand that SEMC engages in educational activities for physicians (including interns and residents), nurses, medical students and other health care personnel, and that such personnel may assist or participate in providing care or treatment to me at SEMC or performing procedures ordered by my physician. I hereby authorize and consent to the assistance or participation of such personnel in my care, treatment or procedures.

4. I understand no assurances or guarantees have been given by anyone concerning treatment or the results that may be obtained.

5. I understand the patient handbook contains information about my right to consent to or refuse medical care and my right to execute Advanced Directives, such as Living Wills and Medical Powers of Attorney.

6. I hereby authorize the taking of pictures and/or the videotaping of the treatment, procedures or operations hereby authorized, and the use of such pictures and/or videotaping for scientific and educational or research purposes. I further authorize SEMC to use its discretion in allowing persons to observe such treatment, operation or procedures in the furtherance of science, education and research.

7. I agree that my conduct will conform with hospital policies. I further agree that SEMC is not responsible for any lost or stolen personal items that I choose to keep with me.

8. I understand that if I chose to leave the inpatient or outpatient unit in which I am located during my treatment I can no longer be monitored or observed by my nurses or care providers at the Medical Center. I further understand that if I am unable to be monitored or observed and my condition gets worse while I am out of the unit, there is a risk to my health that the care providers may not be immediately available to assist me. I acknowledge that I understand this risk and I hereby release and forever discharge my attending physician and the Medical Center from all liability for any and all harm that may result from my decision to leave the unit including, but not limited to, any injuries that may be sustained while I am not being monitored or observed and injuries sustained while leaving, entering, or outside the building.

Continued on the reverse side

Medical Authorization and Release ***(Continued)***

9. I authorize SEMC to release my medical, psychiatric, psychological and /or other information to physicians on SEMC's Medical Staff, and/or to Social/Health/Welfare agencies and other healthcare providers who provide continuing care and/or services after transfer or discharge from the Medical Center.

10. Certain professional services are rendered at St. Elizabeth Medical Center by physicians, residents, medical students, and Durable Medical Equipment (DME) providers, who are independent practitioners and not employees or agents of SEMC. These services include but are not limited to the following: Anesthesiology; Cardiology; Emergency Medicine; Infectious Diseases; Internal Medicine; Neurology; Neurosurgery; Oncology; Pulmonology; Radiology; Surgery; and Urology. St. Elizabeth is not responsible for treatment rendered by physicians, residents, medical students, or DME providers who are not employees of St. Elizabeth Medical Center.

11. I hereby agree and fully understand that if I should refuse treatment or leave the Medical Center without the written consent of my attending physician, I hereby release and hold harmless SEMC, its officers, agents and employees, and the attending physician and his agents and employees for and from all liability for any injuries or damages which may occur on account of my refusal of treatment or my leaving SEMC.

12. I further authorize SEMC or any of my treating physicians to release medical, psychiatric, psychological, and/or other information to the Medical Center's legal counsel, third-party payers, benefit administrators, guarantors and/or other persons as necessary for them to verify benefits, to determine the necessity and appropriateness of my hospital stay or services, to authorize medical services to be received, process claims for benefits, and/or to represent me in a third party payor's hearing and/or appeal process regarding payment for hospital expenses, including, but not limited to, Medicaid's hearing and appeals process.

I HAVE READ BOTH SIDES OF THIS DOCUMENT AND/OR IT HAS BEEN FULLY EXPLAINED TO ME AND I HEREBY CERTIFY THAT I UNDERSTAND ITS CONTENTS:

X _____ _____

Patient Date

_____ _____

Witness 2nd Witness (For Telephone Consent Only)

The patient is unable to consent because:

_____

I therefore consent for the patient**.**

_____ _____

Signature Date

_____ _____

Relationship to Patient Witness

I have received a copy of SEMC's Notice of Privacy Practices (5/1/2008-version)

X _____ _____

Signature Relationship if not patient

Signature unable to be obtained because:_____