Patient Identifier

Name:
Med. Rec. #: *Date of Birth:*
Visit #: *Age:*
Service Date: *Insurance:*
Room: *Service Time:*

CONSENT FOR TREATMENT AGREEMENT

ECMC
ERIE COUNTY MEDICAL CENTER CORPORATION

AUTHORIZATION FOR TREATMENT: I authorize Erie County Medical Center Corporation (ECMCC) and its physicians and other healthcare providers to provide and administer, diagnostic procedures, medical/surgical treatment and perform such other diagnostic or therapeutic procedures as such physicians and other healthcare providers consider necessary for the emergency, inpatient, outpatient and follow up treatment of my condition. No physician, nurse, or other healthcare provider, or ECMCC employee has assured me that such treatment or procedure will be successful. It is acknowledged that the practice of medicine and surgery is not an exact science and that no guarantees have been made or implied as to the results of the treatment or examination at ECMCC. I understand that it is customary, absent emergency or extraordinary circumstances, that no substantial procedures are performed upon a patient unless and until he or she has had an opportunity to discuss them with the physician or other health care professional to his or her satisfaction. I understand that each patient has the right to consent, or to refuse consent, to any proposed course of treatment. Any tissues surgically removed may be examined and retained by ECMCC for medical, scientific or educational purposes or may be disposed of in accordance with customary practice. I understand and acknowledge that ECMCC is designated by New York State as a teaching hospital. As a teaching hospital, ECMCC has a mission to educate and train medical personnel. I understand that ECMCC staff and my Attending Physician will supervise all student involvement in my care. I understand that photographs, videotapes, digital, telehealth/telemedicine, or other images may be recorded or used to document my care and I consent to this. I understand that ECMCC will retain the ownership rights to these photographs, video tapes digital, or other images, but I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in ECMCC's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

AUTHORIZATION TO RELEASE INFORMATION: I consent that ECMCC and its physicians and other healthcare providers and employees may use and disclose protected health information contained in my record to any facility within the ECMCC to any other facility and to any insurance carrier, workers' compensation carrier, or private or governmental third party liable for payment for the services provided to me including an employer or self-funded group health plan. I consent that ECMCC, its physicians, other healthcare providers and employees may furnish information contained in my record to the physician or healthcare provider I have designated as my personal physician or healthcare provider and to any clinic, other entities involved in my care coordination or other facility that I have agreed will provide subsequent medical care and if necessary to the Department of Health (New York State and or Erie County) serving as a public health authority. I further consent to the use and disclosure of my health information for training and educational purposes to students, residents and faculty physicians at universities and colleges affiliated with ECMCC. Such information is to be treated as confidential to the extent required by law.

ACKNOWLEDGEMENT OF DOCUMENTS: I have received or was offered a copy of the "Patients' Bill of Rights", the "ECMC Patient & Family Information Guide" (if admitted) and the "Notice of Privacy Practices".
I consent to receive text messages, phone calls, and other forms of communication from the healthcare team regarding my care, including appointment reminders, follow-up instructions, and other healthcare-related information. I understand that standard data rates may apply for text messaging and phone calls.

Signed: _____ **Date:** _____ **Time:** _____
PATIENT OR AUTHORIZED REPRESENTATIVE

Relationship to Patient (If not self) : _____

Witness Signature	**Date**	**Time**	RELATIONSHIP/IDENTIFY IF CONSENT BY PHONE
Witness Print Name	**Date**	**Time**	
Witness Signature	**Date**	**Time**	RELATIONSHIP/IDENTIFY IF CONSENT BY PHONE
Witness Print Name	**Date**	**Time**	

Personnel identifying patient/family as unable to sign:	Reason unable to sign:
(Please Print):	