University of Kentucky Hospital
Chandler Medical Center
Kentucky Medical Services Foundation
Lexington, Kentucky

AUTHORIZATIONS & AGREEMENTS

ADDRESSOGRAPH

CONSENT TO TREATMENT AND RELEASE OF INFORMATION

Consent to Treatment: I/we voluntary authorize the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of the University of Kentucky Hospital (hereafter referred to as the Hospital), and Chandler Medical Center, and the medical staff, or their designees, as may in their professional judgement be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. I/we acknowledge that no guarantees have been made as to the effect of such examination of treatment on my condition or the condition of the person for whom guarantees have been made as to the effect of such examination or treatment on my condition or the condition of the person for whom I am duly authorized to sign. I/we understand that I/we have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures.

☐ I have formulated Advance Directives (living will, health care surrogate declaration, durable power of attorney) and request that these directives govern my course of care, in as much as is possible under state or federal law. I understand that it is my responsibility to provide the Hospital with a copy of my Advance Directives and that those directives will not govern my course of care until they have been filed in my medical record.

☐ Advance Directives attached ☐ Advance Directives not attached

☐ I have not formulated Advance Directives (living will, health care surrogate declaration, durable power of attorney), but I understand that it is my right to make decisions regarding my course of treatment, including the executing of advanced directives.

Release of Information: I authorize the release from my medical records or the records of the person for whom I am duly authorized to do so, of such medical and/or psychiatric information as may be required by;

1. Any health, sickness, and accident insurance carrier, workman's compensation or agency (social welfare, governmental)which is legally responsible, or which the Hospital has good cause to believe is legally responsible for all or any part of the Medical Center's charges and/or professional fees.
2. Physicians or health care facilities rendering professional care to the patient.
3. The Peer Review Organization responsible for reviewing medical care under Public Law 92-603.

The signed authorization complies with KRS 421.215 rules governing the release of PRIVILEGED information, it assures confidentiality of information and permits the Hospital and KMSF to correspond with those agencies/persons having legitimate interest in the course of care rendered.

Procurement of Information: I/we authorize the release of any medical records of other physicians, hospitals or health care facilities that the Hospital needs for my present medical care or the present medical care of the person for whom I am duly authorized to sign.

This consent may be revoked at any time, except is the extent that action has already been taken, by the patient/duly authorized agent and will expire automatically one year from the date below.

_____ _____ _____

Signature of Patient or Next of Kin, Legal Agent/Guardian And Relationship to Patient | Signature of Witness | Date

FINANCIAL RESPONSIBILITY

Guarantee of Payment: I/we agree to be responsible to the Hospital and Kentucky Medical Services Foundation (hereafter referred to as KMSF) for charges resulting from services rendered at their prevailing rates. I/we agree all bills are due in full upon demand. Should I/we fail to honor this agreement, I/we agree to pay any collection cost or attorney fees resulting from the collection of my accounts.

No granting of extensions, indulgences or forbearances to the patient or any responsible party and no delays or lack of diligence on the part of the Hospital or KMSF in enforcing any rights shall in any manner release the undersigned liability. If the undersigned is more that one person this obligation shall be joint and several. I/we agree the Hospital or KMSF is not party to any disputed claim or peer-review decision which affects payment of any claim filed on my behalf and that upon request for payment from the Hospital or KMSF, I/we agree to pay any outstanding balance.

Assignment of Benefits: I/we hereby assign all rights and privileges and authorize payment directly to the Hospital and KMSF for any claim filed on my behalf or on the behalf of the person for whom I am duly authorized to sign for insurance benefits. I/we agree this assignment is primary to any assignment given after this date including any cost relative to attorney fees. I/We also understand that I/we am financially responsible to the Hospital and KMSF for charges not covered by this assignment or not paid on a timely basis by the insurance company.

Certification: I certify that I have read and understand the authorizations given above and I am the patient, or I am duly authorized by the patient to execute the above and accept its terms.

_____ _____

Date | Signature of Patient or Next of Kin, Legal Agent/guardian or Relationship to Patient

If patient is unable to sign, secure consent of
Next of Kin or Legal Agent and Indicate reason below:

_____

☐ Minor ☐ Disoriented | Signature of Witness

☐ Medically Unstable ☐ Incompetent