OUTPATIENT CONSENT TO TREAT

Patient Name: _____

MRN: _____ DOB: _____

Treatment Location: _____

I. CONSENT TO TREAT

I, _____, am presenting myself/my _____ to the outpatient facility, clinic or practice for a wellness visit, evaluation and/ or treatment of an injury or illness or to address another medical concern.

I authorize the outpatient facility, practice or clinic, its health care practitioners and personnel, including members of its medical staff, and others involved in my care, to examine me and to perform any tests, procedures and treatments that in their judgment may be helpful to care for my injury or illness or facilitate my preventive care.

I understand that the health care professionals responsible for this care will explain any proposed procedures or treatments, including their usual and most frequent risks and hazards. I also understand that I have the right to refuse any proposed procedure or treatment.

I understand that information concerning my diagnosis and treatment will be available to other health care professionals and facilities involved in my ongoing care or treatment, including private practicing physicians, and for other lawful functions of the facility.

I understand that I may complete an Advance Directive. An Advance Directive allows me to direct the type of care that I will receive if I become unable to decide for myself. It also allows me to choose someone to make those decisions for me.

I understand that physicians in training, including fellows and residents, as well as medical students, nursing students and other trainees acting under the supervision of attending physicians or supervisory nurses and other professionals, may observe and may assist in diagnosis, treatment and care.

I understand that some of my evaluation and care will be provided by physicians and other individuals employed by MaineHealth member facilities; some care may be provided by physicians and their assistants in their own private practice. Some surgeons, critical care physicians, and other specialists are authorized to provide care at the practice or clinic as members of their own private practice. Anesthesia, radiology, and pathology services are provided by physicians employed by Spectrum Healthcare Partners or another physician group. My primary care physician and my treating physicians can explain on request my options for selecting treating physicians at another hospital or practice.

I understand that the outpatient facility, practice or clinic may allow specimens (such as tissue, blood or other fluids) that are not needed for my diagnosis or treatment, and would otherwise be disposed of, to be used for research or teaching purposes. I understand that my health information also may be used for research or teaching purposes. Nothing that could identify me will be included in the information used for research or teaching purposes.

II. RELEASE/DISCLOSURE OF INFORMATION

I understand that the outpatient facility's, clinic's or practice's policy is to maintain patient healthcare information as confidential and not to disclose such information unless the disclosure is permitted or required by law or I have authorized the disclosure. By law, patient healthcare information may be disclosed ***without an authorization*** to family or household members unless expressly prohibited by the patient or the patient's authorized representative. I further understand that the healthcare practitioners responsible for this care may share my healthcare information orally or in writing with my family or household members involved in my care as necessary or directed by me. I will be asked by my clinician whether I agree to discuss my medical condition in the presence of visitors who may be in the exam room at the time of my clinician visit. If I do not wish for my medical condition to be discussed in the presence of visitors, then it is my responsibility to ask the visitors to leave the exam room during my conversations with clinicians.

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I UNDERSTAND THAT UNDER MAINE LAW, HEALTH PROFESSIONALS AND HOSPITALS MAY DISCLOSE SOME HEALTH AND CLAIMS INFORMATION TO THIRD PARTIES AND THAT ALL OF THESE DISCLOSURES ARE LIMITED TO THE AMOUNT OF INFORMATION REASONABLY REQUESTED OR NEEDED.

I hereby authorize the outpatient facility, clinic or practice, and its healthcare practitioners and personnel to make the following continuing uses and disclosures of information relating to my evaluation and treatment and claims data to the extent necessary:

To primary care and other healthcare practitioners or facilities who have been or may become involved in my care both within and outside the State of Maine; to clinical and non-clinical personnel who may now or in the future become involved in both the management and transition of my care between hospitals, medical practices, other health care facilities and home including care coordination and case management services; and for other lawful functions;

- To outside organizations that carry out benchmarking functions for quality and cost performance, utilization review, and comparison of health care interventions to determine which work best for certain patient populations for my healthcare providers, with the understanding that I will not be individually identified in any reports from these organizations;
- To individuals, companies and governmental agencies that may be responsible for paying for my care including insurance carriers and their health claim reviewers. This authorization is effective until final payment is received or 30 months from today (whichever is sooner);
- To contracted agents for the identification of current and potential third party resources available for payment of services, determination of a patient's eligibility or coverage in a health benefits plan, and provision of related advocacy initiatives to access insurance benefits or other resources;
- To HealthInfoNet (HIN), a state-wide arrangement of health care organizations who have agreed to work with each other to make available electronic health information that may be relevant to my care. I understand that I may choose to not make my health information available to HIN by completing the paperwork provided to me during the registration process and sending it to HIN at the designated address; and
- Photographs and videos may be made for the purposes of diagnosis, teaching, and documentation within the MaineHealth system. I reserve the right to give specific permission for the external publication of any image that personally identifies me.

I understand that:

- I may request in writing to revoke all or part of these authorizations at any time by notifying the outpatient facility, clinic or practice in writing. I understand that the revocation shall not apply to any disclosures made prior to receiving notice of the revocation.
- HIPAA provides the opportunity to request limits on the disclosure of your health information. However, HIPAA does not require that the Hospital agrees to all such requests. Information recorded in an electronic health record cannot always be easily isolated from further use or disclosure. If the Hospital is able to agree with such requests, I understand that the Hospital may still disclose the information when needed to provide you with emergency treatment or when required by law and that in some circumstances disclosures may occur despite the Hospital's efforts to restrict them. The Hospital is required to agree to your request to not provide your insurance carrier with your health information if you have paid in full for the health care services.
- The refusal or revocation of my authorization to release some or all of the information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- I may request a copy of this form.
- This authorization is effective for one (1) year from the date of signing. I authorize future disclosures to the same individual and/or entities during this time period.

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III. SPECIALIZED RELEASES FOR SENSITIVE HEALTH INFORMATION

If I have been diagnosed or treated for HIV, or diagnosed or treated by a mental health or substance abuse treatment program, I understand that the outpatient facility, clinic or practice usually will obtain my specific consent on a separate authorization form to disclose related information to a third party.

I hereby agree to the disclosure of all substance use disorder information including without limitation medications, substance use history, employment information, living situation, and social supports to my treating providers as well as participating accountable care organizations and health information exchanges for purposes of care coordination and case management services.

References to sensitive health information may nevertheless be available to authorized users within the Shared Electronic Health Record (SeHR) including the problem list, medication list, diagnosis and allergy fields, and such information may also be available to the Hospital's medical staff, healthcare practitioners and administrative personnel for the purposes of: (i) my evaluation, diagnosis or treatment to ensure quality of care and patient safety; (ii) to complete the responsibilities of the healthcare practitioners involved in my evaluation, diagnosis or treatment; (iii) inclusion in continuity of care documents for planned and unplanned transitions of care; and (iv) payment of the costs associated with my evaluation, diagnosis and treatment; I hereby consent to such disclosures. The availability of such information for these purposes is limited by both technological access controls and internal protocols, and also is subject to auditing.

IV. PAYMENT AND/OR ASSIGNMENT OF BENEFITS

I understand that I am responsible for paying all costs associated with my evaluation and care. If I have health insurance, I understand that I am financially responsible in the event that all or some payment is denied by my insurance carrier or another third party who is responsible for payment. I also am responsible for those charges not covered by my insurance, such as deductibles, co-pays, or evaluations or treatment that are not included as an insurance benefit. This includes services rendered to me that may not meet medical necessity as defined by my insurance carrier.

I authorize my health insurance carrier(s) or other financially obligated third parties, including Medicare and Medicaid, to pay the costs associated with my evaluation and care directly to the outpatient facility, clinic or practice and members of the Medical Staff involved in my care, and as part of this authorization, I assign to the Hospital and members of the medical staff involved in my care my rights to receive reimbursement under any applicable insurance policy, or program or plan for my obligations to pay for such care. I further authorize the outpatient facility, clinic or practice to release information relating to the billing and filing of claims for reimbursement for medical care delivered to me to the health care provider responsible for the cost of my care and to ambulance units who transport me to the Hospital or one of its affiliates.

Patient or Authorized Representative Signature	Date| Time AM/PM	Witness Signature

Witnessed personally ☐ Witnessed via telephone ☐ Interpreter ☐

Interpreter Print Name	Interpreter Signature