The Saratoga Hospital

General Consent for Diagnosis and Treatment

DOB: Age: Sex:
ADM/SVC Date: Arrival Time:
Loc:

MR#:

Consent: I, or (print name) _____ (for the patient) authorize and give my consent to the medical staff, their designates, and the staff of The Saratoga Hospital for such examination(s), therapy(ies), treatment(s), test(s), or procedure(s), to be performed upon me as, in their judgement, are necessary or advisable to my diagnosis, treatment, or care. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me as to the results or effects of any examination(s), therapy(ies), treatment(s), test(s), or procedure(s).

Release of Liability for Personal Property: I hereby release The Saratoga Hospital and its staff from all responsibility for any loss or damage to personal property not deposited with the Hospital's Security Office for safekeeping before services are rendered. I understand that the Hospital assumes no liability or responsibility for the loss or theft of any personal property I choose to retain during my hospital stay or other service, including but not limited to, jewelry, money, clothing, dentures, eyeglasses, and hearing aids. I further release The Saratoga Hospital from any responsibility with respect to any personal property that I may leave behind in the Hospital that is not claimed within 30 days of my discharge.

Staff: I understand that most of the physicians and other members of the medical staff of The Saratoga Hospital are not employees or agents of the Hospital, but rather, are independent contractors who have been granted the privilege of using the Hospital's facilities for the care and treatment of their patients. Further, I understand that The Saratoga Hospital is a teaching facility and that my physician(s) may be assisted in my diagnosis and treatment by one or more students, physicians, nurses or other health care professionals in training.

Release of Information: I agree that The Saratoga Hospital and its medical staff may disclose all or part of my medical records to others in order to treat my condition, obtain payment for that treatment, and run Saratoga Hospital's normal business operations. My protected health information may also be shared with affiliated hospitals and health care providers so that they may jointly perform certain payment activities and business operations along with Saratoga Hospital.

Patients' Bill of Rights: I have received a copy of the Patients' Bill of Rights and understand that I can be assisted with any questions.

Notice to Our Patients: I have received a copy of the Notice to our Patients, which includes information regarding visitation and grievance.

This form has been fully explained to me and I am satisfied that I understand its contents and significance.

Print patient / Relative / Guardian Name	Signature	Date	Time
Relationship to Patient	Reason for Signature		
Print Interpreter Name (if required)	Signature	Date	Time
Witnessed by (print name)	WITNESS SIGNATURE	Date	Time
Witnessed by (print name)	WITNESS SIGNATURE	Date	Time

Two Witness Signatures are required for patient mark, telephone or verbal consent only