

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I present myself for medical services which may include an admission or transfer to the comprehensive rehabilitation or behavioral health unit at an NCH Healthcare System facility. I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment by employees and members of the independent medical staff of the NCH Healthcare System facility or their designee as may be deemed necessary or beneficial.

1. Medical Record Release/Access: I authorize release of medical records to all independent physicians involved in my care, to my attending physician and any follow-up physicians. I authorize the NCH Healthcare System to allow outside agencies access to my medical record for treatment and discharge planning purposes, when required to arrange for my continued medical care and discharge needs following my discharge from the hospital. I also authorize the release of my medical record to outside agencies, such as home healthcare agencies, skilled nursing facilities, hospice and adult congregate living facilities, when I have consented to referrals to these agencies.
2. Residents & Students: I understand that health care providers in training, including medical students and resident physicians, may be involved in my care and treatment and I consent to their involvement in my care.
3. Prescription History: The NCH Healthcare System utilizes an electronic medical record system, and this allows access to your prescription history, drug benefit coverage and enables new prescriptions to be electronically routed to the pharmacy of your choice.

I hereby acknowledge and/or agree to the following:

That the Hospital does not control the medical decisions, diagnosis or treatment rendered by the physicians, residents, and/or allied health professionals treating me in the Hospital; that the emergency physicians, anesthesiologists, pathologists, radiologists and hospitalists practicing in the hospital are NOT agents or employees of the Hospital but are independent practitioners; that the allied health professionals practicing in this hospital who are not employed by NCH Healthcare System, Inc. or NCH Physician Group are independent practitioners; that the Hospital delegates to physicians, residents, and/or their allied health professionals the providing of physician and/or allied health professional services to the patient, which operates to discharge the Hospital from any contractual obligations to provide said services to the patient; that the Hospital is not legally or vicariously responsible for the conduct or actions of the emergency physicians, anesthesiologists, pathologists, radiologists or hospitalists practicing in this Hospital; that the Hospital is not legally or vicariously responsible for the conduct or actions of the allied health professionals practicing in this Hospital who are not employed by NCH Healthcare System, Inc. or NCH Physician Group.

That the undersigned does hereby release the Hospital, its agents, employees, officers and directors, from liability for all acts of the aforesaid physicians and/or allied health professionals, negligent or otherwise.

Please check here If "Patient Unable to Sign", then date/time and witness this document.

Patient/Guarantor or Authorized Representative

Date / Time

Witness

Relationship to Patient

MODERNA COVID 19 VACCINE INFORMATION

I ACKNOWLEDGE THAT I RECEIVED THE “FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) OF THE MODERNA COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER”. INITIALS _____