CALVARY HOSPITAL
Where Life Continues

Bronx Campus: 1740 Eastchester Road, Bronx, N.Y. 10461
Brooklyn Campus: 3rd Floor - Lutheran Medical Center;
150 55th Street, Brooklyn, NY 11220

INDIVIDUAL CONSENT

Patient Name: _____

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment we must obtain your written consent before we may use or disclose your information as necessary to provide you with medical care, collect payment for that care, and run the normal business operations of the hospital. Please read carefully the information below before signing this form.

SPECIFIC UNDERSTANDINGS

Scope of Consent

By signing this consent form, you:

A. Authorize admission to Calvary Hospital, and/or its clinical departments or divisions and authorize Calvary Hospital, the physicians, dentists, and allied health professionals on its staff, the members of its House Staff, Nursing Staff, and Paramedical Staff, assisted by employees of Calvary Hospital, to provide such medical and/or dental care and to administer such routine diagnostic tests and procedures, including but not limited to, diagnostic x-rays; the administration and/or injection of pharmaceutical products and medications; the drawing and/or administration of blood pooled plasma, or other blood derivatives, as the attending physician and the above Calvary Hospital personnel deem necessary or advisable for care. You also authorize the taking or making of photographs in connection with the medical, research and education and other services received at the hospital center.

B. Permit the hospital and its medical staff to share your protected health information for treatment, payment and normal business operations within the hospital setting. You will also permit the hospital and its medical staff to share your information with other persons or organizations outside the hospital that perform payment activities and business operations jointly with the hospital.

C. Acknowledge that no guarantees have been made to you as the result of treatment or examination in Calvary Hospital.

INDIVIDUAL CONSENT

Revoking Consent

You have a right to revoke this consent anytime except to the extent that the hospital has already taken action based upon your consent. For example, if you revoke your consent after the hospital has provided you with treatment, the hospital will be permitted to use or disclose your protected health information to bill for that treatment even after you revoke your consent. To revoke this consent, please write to:

Jesus Kaiser, MS-HIM, RHIA
Director of Health Information Management
1740 Eastchester Road
Bronx, New York 10461

CONSENT SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Signature of Patient or Personal Representative Date/Time

Witness (**Telephone Consent Only**) Witness (**Telephone Consent Only**)

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CONTACT INFORMATION

The contact information of the patient or personal representative who signed this form should be filled in below:

Address:

_____
_____
_____
_____

Telephone:

_____(daytime)
_____(evening)

Email Address (optional):

_____