UW Medicine
VALLEY
MEDICAL CENTER

CONSENT TO CARE AND TREATMENT AT VALLEY MEDICAL CENTER (FOR USE IN HOSPITAL ONLY)

HOSPITAL AND MEDICAL TREATMENT: I, the undersigned, hereby consent to and permit my attending physician and his/her designees, the Hospital and its employees, and all other persons caring for me to provide me treatment and care as may be deemed necessary and available to me during my stay in the Hospital, including but not limited to tests, examinations, anesthetics, x-rays and medical and surgical treatments, and other necessary procedures.

I understand that my care is under the control of my attending physicians who may not be employees or agents of the Hospital, but rather, independent physicians, and that the Hospital is not liable for their acts or omissions or any acts or omissions from following their instructions. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the result of treatment or examination in the Hospital.

In the event a healthcare worker is exposed to my blood or body fluid in a manner that may pose a risk for transmission of a blood-borne infection during this hospitalization, I am giving my consent to be tested for HIV, at no cost to me, so the healthcare worker can be treated promptly. I authorize release of this information to the exposed healthcare worker and his/her healthcare provider.

PHOTOGRAPHS The taking, reproduction and use of photographs in connection with my diagnosis, care and treatment (including surgical procedures) at the Hospital is approved, provided my identity is not revealed. Photographs may include the use of videotapes, television and digital imaging. These images may become part of the medical record.

PATIENT PROPERTY: I am aware that the Hospital is not liable for the loss or damage of any personal property unless placed in the Hospital safe.

DIRECTORY INFORMATION: Unless otherwise requested, the Hospital may acknowledge my presence, location and condition (fair, serious, critical), to callers and/or visitors

CONSENT TO TREATMENT BY STUDENT MEDICAL PROFESSIONAL: As a part of a policy of continuing medical education, the Hospital has medical, nursing and paramedical students observing or participating in the care provided for its patients. I understand that this may include surgical procedures, x-ray procedures, examination of tissue, and other aspects of my care. I further understand that at all times these activities will be under the supervision and approval of my physicians and/or other licensed health care professionals and will be at a level deemed appropriate and necessary by them, and I consent to the observation and participation of medical and paramedical students in the medical care provided for me while I am a patient at the Hospital.

NOTICE TO MATERNITY PATIENTS: My authorization today for my care and the care of my baby will apply to care I may receive today as well as future care related to my present pregnancy, up to and including my delivery. I understand that my Obstetrician may be unavailable, and dependent upon physician coverage, I may not be able to choose whether my physician is male or female.

PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge the receipt of the abridged version of the Patient Rights and Responsibilities and understand that a complete version will be provided to me at my request.

ADVANCE DIRECTIVES/LIVING WILL: I acknowledge the receipt of information regarding Advance Directives and the Durable Power of Attorney for Healthcare.

I CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I UNDERSTAND ITS CONTENT. MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I CONSENT TO TREATMENT AND CARE AT VALLEY MEDICAL CENTER. I ACKNOWLEDGE RECEIPT OF NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES AND INFORMATION REGARDING ADVANCE DIRECTIVES.

Signature (Patient or Person Authorized)		Date
Witness: (Optional unless a telephone consent, or as requested by the LIP)		Date
If signed by person other than patient, relationship to patient:	If Patient unable to sign, reason:	Verbal Obtained? ☐ **No** ☐ **Yes**