Student Name:_____ Student ID#_____

PARKLAND HEALTH
Dallas, Texas

AMBULATORY CONSENT TO MEDICAL TREATMENT

ACT296

Place Demographic Label Here
If label not available, please complete manually.

MRN:_____ Name (Last, First): _____

DOB: _____ Race:_____

HAR: _____ Sex:_____

CSN: _____ Location: _____

CONSENT FOR MEDICAL TREATMENT AND PHOTOGRAPHY

- I do hereby voluntarily consent to and authorize Parkland Health (Parkland) to provide care encompassing all diagnostic and therapeutic treatments, including HIV testing, considered necessary or advisable in the judgment of the attending physician or his/her designee. By signing this form, I do not waive my right to refuse recommended tests or treatments.
- I understand that Parkland functions in part as a teaching institution and I hereby acknowledge and consent to the use of myself and related records, laboratory work and specimens and diagnostic results from time to time for instructional purposes or machine testing at the sole discretion of Parkland.
- I understand that photographs, videotapes, digital and other images may be recorded to document my care, and I consent to this. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Parkland procedures. Images that identify me will be released or used outside Parkland only upon written authorization from me or my legal representative.

ACKNOWLEDGEMENT OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION I UNDERSTAND:

- Parkland personnel and my physician create and maintain a record of the care and services provided to me.
- Information relating to my treatment, payment or health care operations may be used or disclosed in the management and delivery of care and services provided by Parkland.
- I have received a copy of Parkland's Notice of Privacy Practices that describes how my protected health information may be used or disclosed.
- I have received, read and understand the Patient Bill of Rights located on the back of this form.

NOTICE OF EXCHANGE OF MEDICAL RECORD

I acknowledge that Parkland participates in an electronic medical record exchange program and shares and/or receives information about me with other physicians and health care facilities that provide my care. The exchange includes diagnosis and treatment information available in my medical record and is provided for treatment purposes only. The records exchanged may include sensitive health information such as genetic testing, mental health information, communicable disease, pregnancy, chemical dependency and behavioral health. If I do not wish to have my information shared or received through the electronic exchange, I agree to notify my nurse or physician.

PRESERVATION OF RECORDS

Parkland **MAY** authorize disposal of medical records relating to the patient on or after the time periods specified in the Texas Health and Safety code.

PATIENT PROPERTY

I understand that Parkland does not assume the responsibility for the safekeeping of any personal property that I choose to keep during my stay (including, but not limited to wallets, purses, dentures, hearing aids, cell phones, personal computers/electronics, canes, clothing, jewelry, eye glasses, contact lenses or any other valuables).

I have read and understand the front and back of this form. The information has been explained to me to my satisfaction, I accept and agree to the items contained in this Ambulatory Consent to Medical Treatment.

Patient, Guardian or Legally Authorized Representative Signature	Patient, Guardian or Legally Authorized Representative Printed Name		Date	Time
Relationship to Patient (if applicable)				
Parkland Representative Signature	Parkland Representative Printed Name	ID #	Date	Time
Interpreter Signature, if applicable	Interpreter Printed Name	ID #	Date	Time

WHITE COPY - Patient Medical Record **YELLOW COPY** - Patient

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PATIENT RIGHTS AND RESPONSIBILITIES

AS A PATIENT, YOU HAVE THE RIGHT TO:

1. participate in the development and implementation of your plan of care.
2. information necessary to make informed decisions regarding your care, treatment, and services.
3. request, accept or refuse treatment, to be informed of the medical consequences of refusal.
4. formulate advance directives, have hospital staff and practitioners comply with those directives, and appoint a surrogate to make health care decisions on your behalf.
5. have individuals and physicians of your choice notified promptly of your admission to the hospital.
6. personal privacy and an environment that preserves dignity and contributes to your positive self image.
7. receive considerate and respectful care (including consideration of the psychosocial, spiritual, and cultural variables that influence the perceptions of illness).
8. receive care in a safe setting, free from all forms of neglect, exploitation, abuse and harassment.
9. confidentiality of your information and clinical records.
10. access to information in your clinical records by you and your legally designated representative within a reasonable time frame.
11. freedom from restraint or seclusion that is not medically necessary or not imposed to ensure the immediate physical safety of you, staff or others and safe implementation of restraint or seclusion when used.
12. receive visitors (including support persons), subject to clinical restrictions or limitation, including the right to determine who may or may not visit.
13. reasonable response to request and needs for treatment or service regardless of age, race, ethnicity, national origin, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression.
14. end-of-life care that optimizes comfort and dignity, effectively manages pain and includes consideration of psychosocial, spiritual and cultural concerns.
15. receive information about patient rights and patient complaint resolution processed.
16. participation in discussion and resolution or ethical issues that affect your care.
17. to be informed of any experimentation, research or educational projects affecting your treatment and refuse to participate in any such activities without jeopardizing your access to care.
18. have a legally authorized representative exercise these rights on your behalf to the extent permitted by law.
19. receive information in a manner that you can understand.
20. give or withhold consent regarding the production or use of recordings, films, photographs, videos, or other images of you for purposes other than the provision of care, and also to receive the cessation of such production or use.
21. receive information about the individuals responsible for providing your care, including student doctors, nurses, and other healthcare providers who assist in care.
22. access protective and advocacy services.
23. receive information about hospital policy regarding Cardiopulmonary Resuscitation (CPR) in the event your circulatory or respiratory function stops and communicate your wishes and be involved in treatment decisions regarding CPR.

A MINOR RECEIVING COMPREHENSIVE MEDICAL REHABILITATION SERVICES IS ENTITLED TO:

1. appropriate treatment in the least restrictive setting available.
2. not receive unnecessary or excessive medication.
3. an individualized treatment plan and to participate in the development of the plan.
4. a humane treatment environment that provides reasonable protection from harm and appropriate privacy for personal needs.
5. separation from adult patients.
6. regular communication between the minor patient and the patient's family.

AS A PATIENT, YOU HAVE THE RESPONSIBILITY TO:

1. provide complete and accurate information that facilitates your care, treatment and services.
2. ask questions or acknowledge when you do not understand the treatment course or care decision.
3. follow your treatment plan and the hospital's instructions, rules and regulations.
4. respect the rights of others, being considerate and respectful of patients, visitors and staff.
5. fulfill financial obligations to the hospital and physician.
6. gain consent from your nurse or clinical team prior to leaving your treatment unit each time. If approved, you will return within 1 hour. You will only go to first floor of the hospital or garden area.

CONCERN REGARDING YOUR CARE

You have the right to tell us when you have a concern or complaint about your health care services. If you present a concern, your care will not be affected in any way. An issue can be addressed most promptly by talking with your nurse or other health care provider. If you feel an issue is not being addressed appropriately, please contact the Parkland Patient Relations Department at 469-419-0820. A representative will contact you within 48 hours. You may file a complaint directly with an oversight agency regardless of whether you have used the Parkland complaint process. If you feel your concern is not being addressed by Parkland, you may contact:

Texas Department of State Health Services
Health Facility Compliance Group (MC1979)
P.O. Box 149347
Austin, TX 78714-9347
888-973-0022

The Joint Commission
Office of Quality and Patient Safety
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
1-800-994-6610
Fax: 630-792-5636

KEPRO (for Medicare patients)
5201 West Kennedy Boulevard, Suite 900
Tampa, FL 33609
1-888-315-0636 or TTY 1-855-843-4776
Toll-free Fax: 844-878-7921

Office for Civil Rights (discrimination concerns)
U.S. Department of Health & Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202
800-669-4000