UW Medicine
VALLEY
MEDICAL CENTER

CONSENT TO CARE AND TREATMENT AT VALLEY MEDICAL CENTER
FOR USE IN CLINIC NETWORK ONLY

CLINIC NETWORK AND MEDICAL TREATMENT: I, the undersigned, hereby consent to and permit my attending physician and his/her designees, the Clinic Network 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 office visit or outpatient procedure, including but not limited to tests, examinations, anesthetics, x-rays and medical and surgical treatments, and other necessary procedures. I understand that by signing this Consent, I am authorizing them to treat me for as long as I seek care from Valley Medical Center Clinic Network Providers or until I withdraw my consent in writing.

I understand that my care is under the control of my attending physicians who may not be employees or agents of the Clinic Network, but rather, independent physicians, and that the Clinic Network 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 Clinic Network.

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 office visit or outpatient procedure, 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 Clinic Network 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.

CONSENT TO TREATMENT BY STUDENT MEDICAL PROFESSIONAL: As a part of a policy of continuing medical education, the Clinic Network 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 Clinic Network.

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

NOTICE TO OUTPATIENTS: If the visit today is for a series of outpatient treatments, your authorization for outpatient care and services in this department is required once per calendar year.

RECEIPT OF ELECTRONIC MAIL: I acknowledge that giving my email authorizes solely Valley Medical Clinic Network Providers to send me health promotion and patient care announcements. My information will not be sold or disclosed to any third parties.

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.

Print Name (Patient or Person Authorized*)		
Signature (Patient or Person Authorized)	Date:	Time:
Witness:	Date:	Time:
*If signed by person other than patient, please print name, relationship to patient, and description of authority:		
☐ Patient unable to sign Reason:	Verbal Obtained? ☐ No	☐ Yes