EMERGENCY DEPARTMENT
ROANOKE MEMORIAL HOSPITAL
GENERAL CONSENT FOR TREATMENT

1. CONSENT TO TREATMENT: I hereby authorize the employees, agents and staff of the Hospital to perform, and hereby consent to such medical treatment and examinations, including diagnostic procedures and blood transfusions, as may in the opinion of the patient's physician be necessary.

2. NO GUARANTEE: I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the result of any procedures, treatments, or examinations. I understand that the risks of hospitalization may include, but are not limited to, infection with multi-drug resistant organisms.

3. TEACHING HOSPITAL: I am aware that this is a teaching Hospital, and that certain patient services may be performed or observed by students or trainees in the health profession, under the supervision of the staff or employees of the Hospital.

4. DEEMED CONSENT FOR BLOOD TESTING: I understand that, under Virginia Law, whenever a health care provider or any person employed by or under the direction and control of a healthcare provider is directly exposed to body fluids of a patient in a manner (such as through accidental needle stick) which may transmit viruses which could cause HIV or Hepatitis B or C, the patient will be deemed to have consented to testing for HIV or Hepatitis B or C, and to the release of such test results to the person who was exposed. Patients who test positive will be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling.

5. RELEASE, DISCLOSURE, and Use of PATIENT INFORMATION (including protected health information): I understand that Carilion uses an Electronic Medical Record. I authorize Carilion to obtain my/the patient's health information from other health care providers and health care facilities and to release my/the patient's health information to any physician involved in my treatment; any health care facility to which I/the patient is discharged, transferred, and/or presents for treatment; other health care providers; affiliates of Carilion and business partners for the purposes of treatment, payment, and health care operations including but not limited to billing, healthcare management, discharge planning, quality assurance, bill collection, defense of litigation or anticipated litigation; and/or to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by Carilion. I also authorize use of information to determine if I have insurance coverage or other benefits and, if I do, agree that Carilion Clinic may bill discovered coverage according to the scope of this consent. I consent to the use, release, and disclosure of my/the patient's protected health information for all the above reasons. I understand that my health information may be transmitted in electronic or paper format or verbally. I authorize Carilion to access and use my patient prescription information from any health care provider or benefits manager including prescriptions that have been submitted for claims to any insurance plan. I understand that I have a right to request restrictions on how my health information is used or disclosed for treatment, payment and health care operations, and that Carilion is not required to agree to such a restriction request.

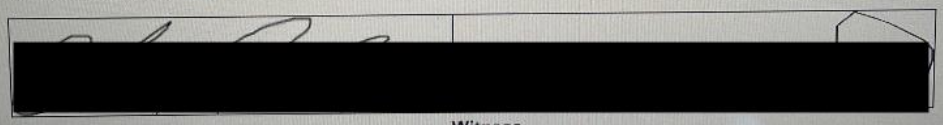
6. CONSENT TO WIRELESS TELEPHONE CALLS: If, at any time, I provide a wireless telephone number to Carilion at which I may be contacted, I consent to receive calls (including autodialed calls and pre-recorded messages, automated appointment reminders) at that wireless number from Carilion, its successors and assigns, and its affiliates, agents and independent contractors, including collection agents, regarding the services rendered, hospitalization, and/or my related financial obligations.

7. VALUABLES: I understand that the Hospital will not be responsible for any valuables or other such personal property left unattended in the Hospital. Accordingly, I assume the risk of loss or theft or any personal property not deposited with the Hospital for safekeeping, and agree to hold the Hospital harmless from any and all liability which may result from the loss of any such personal property.

8. CERTIFICATION AND ACKNOWLEDGEMENT: I certify that the foregoing information and all information supplied by me as a part of the admission/registration process is correct. I acknowledge receipt of the Carilion Health System Notice of Privacy Practices.

9. HEALTH INFORMATION EXCHANGE(HIE) GENERAL CONSENT: To improve the coordination of my care, I authorize Carilion Clinic to electronically release my protected health information to other healthcare providers involved in my care and treatment who participate in local, state, national and/or international Health Information Exchanges. This may include information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases (STDs), HIV test results, developmental disabilities and genetic testing results.

Relation to Patient: Self



Witness

Date: [redacted], 2021 **Time:** 7:04 PM