I, _____, parent/guardian of

_____, am unable to attend the

West Mifflin Flu Shot Clinic with the AHN Mobile Clinic on **Friday, November 8th** and give my

written permission for the student listed above to be seen in the absence of a parent or legal

guardian.

Parent/Legal Guardian Signature:

_____

Date:

_____

Act 52 of 1999 Medical Consent Act

I, _____, am the parent of the child(ren) listed below and there are no court orders now
(Parent's Name)
in effect that would prohibit me from conferring the power to consent upon another person.

I, _____, am the legal guardian or legal custodian of the child(ren) by court order
(Name of Legal Guardian or Legal Custodian)
(copy attached, if available), and there are no other court orders in effect that would prohibit me from conferring the power to cosent upon another person.

I, _____, do hereby confer upon _____, residing at
(Name of Parent or Legal Guardian or Custodian) (Name of Person Bringing Child(ren) for Care)
_____ the power to consent to necessary medical or mental health treatment for the following:

child(ren): 1) _____ 2) _____ 3) _____,

residing at: _____,

born on: 1) _____ 2) _____ 3) _____,

and on the child(ren)'s behalf do hereby state that the power to consent that I confer shall not be affected by my subsequent disability or incapacity. The power that I confer is specifically limited to health care and mental health care decision making, and it may be exercised only by the person named above.

The person named above may consent to the following examinations and treatment for my child(ren): (check all that apply)

_____ medical, _____ surgical, _____ mental health,

_____ dental, _____ developmental, _____ _____,
(Other Treatment Child(ren) May Receive)

and may have access to records and information with regard to the health care services and insurance.

I confer the power to consent freely and knowingly in order to provide for the child(ren) and not as a result of pressure, threats or payments by any person or agency. This document shall remain in effect until it is revoked by my written notification to my child(ren)'s medical, mental health care, and insurance providers, and the person named above. **I also acknowledge and agree that this authorization becomes revoked upon my death.**

In witness whereof, I have signed my name to this medical consent authorization, on this

_____ day of _____, 20_____ in _____, Pennsylvania.

(Printed Name) _____

(Signature) _____ DATE _____ TIME _____

_____ _____ _____
(Witness Signature No. 1 – **must be 18 or older**) DATE TIME

_____
(Witness No. 1 Printed Name and Address)

_____ _____ _____
(Witness Signature No. 2 – **must be 18 or older**) DATE TIME

_____
(Witness No. 2 Printed Name and Address)

_____ _____ _____
(Signature of Adult Person who is Being Given Power to Consent) DATE TIME

AHN
Allegheny Health Network

201114

Consent to Treat a Minor in the Absence of a Parent/Legal Guardian

Patient Identification

This form applies to all of your inpatient, outpatient and physician office services within Allegheny Health Network (AHN).

CONSENT TO TREATMENT

I request those physicians and other health care professionals who care for me, to perform routine diagnostic procedures, hospital care and therapeutic treatments, which in their judgment, become necessary while I am a patient of the physicians and facilities of AHN. Routine diagnostic procedures and medical treatments include but are not limited to x-rays, physical therapy, blood tests and administration of medications and other diagnostic monitoring measures. I also consent to medical recording or filming necessary in the judgment of my physician, to document the course of my injury or illness and to provide appropriate medical care, performance improvement and education. I agree to have my photo taken for identification purposes. Where applicable to maternity cases, I acknowledge that a photograph of my newborn baby may be taken for security purposes.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations. I authorize the physicians and other health care professionals of AHN to retain, preserve and use for scientific, or educational purposes, or dispose of at their convenience, any specimens or tissue taken from my body during my hospitalization. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for educational purposes.

I understand that AHN is an organized health care arrangement consisting of hospitals and primary and specialty care practices. Sharing my protected health information among its providers is essential for my care. I further understand that other community providers may also need to access my protected health information throughout AHN and with other community providers to allow for efficient care management and delivery.

By providing my phone number, I agree that the employees, agents, allied health professionals, contractors, or other representatives of AHN and its subsidiaries and affiliates, and/or any party contracted on their behalf, may contact me using automated dialing, pre-recorded script, interactive voice response, and/or text messaging technologies for health care related or account administration related communications, including but not limited to appointment and wellness reminders, results, or prescription refill notifications, care or benefit coordination activities, pre and post-operative or home health instructions, collection of financial liabilities owed, customer service or quality improvement operations, inquiries regarding participation in research studies, and/or for other non-telemarketing purposes. I understand that I may opt out of these types of communication methods without impacting my ability to receive care.

CONSENT TO TELEHEALTH ENCOUNTER

I understand that there are potential benefits of participating in telehealth, including care coordination, health management, and outcome improvement. If applicable, I hereby consent to a telehealth encounter for evaluation, diagnosis, and treatment. The telehealth encounter may occur with an off-site provider using two-way videoconferencing equipment, an online health questionnaire, secure messaging or other approved electronic means to transmit my health data. I understand that information used during this encounter may include my medical records and images, audio and video recordings, and output data from devices. I acknowledge that I have the right and opportunity to ask questions about this process.

I am aware that laws protecting the privacy and security of my health information apply to telehealth. I further understand that information will be transmitted over a secure network, and if stored, will be saved in a data repository protected by security protocols. I acknowledge that information obtained or recorded during the course of an encounter may become part of a designated record set, and I may request access to such information.

I acknowledge and accept that there may be risks associated with telehealth, including the quality of transmitted information, the ability to fully evaluate and diagnose certain conditions, delays in the encounter due to equipment limitations, and in rare cases, a security protocol failure. I acknowledge that alternative methods to telehealth may be presented to me if they are available, and I will have an opportunity to ask questions about such alternatives.

I acknowledge that I have the right to withdraw my consent to the use of telehealth, and will be advised of any impact to my care, such as treatment delay or potential cost related to transfer.

Allegheny Health Network

201016

Consent to Treatment, Release and Acknowledgement

Patient Identification

RELEASE OF RESPONSIBILITY

I understand that if I leave the facilities of AHN without the consent of the physician and/or fail to carry out instructions for follow-up care, I am doing so of my own free will. I further understand that any injury or harm I may suffer while away from the facilities of AHN will be entirely my responsibility. I further release the physicians, other health care professional agents, servants and employees of AHN from any claim by me or anyone on my behalf for the injuries or harm suffered while away from the facilities of AHN.

I understand that I am responsible for the security and whereabouts of any money, documents, personal items or other articles of unusual value unless such valuables are deposited with the appropriate office/personnel for safekeeping. All clothing, eyeglasses, contact lenses, dentures, hearing aids, jewelry, cash or other personal property that I wish to keep with me while I am at an appointment or receiving treatment is at my own risk as to loss or damage. I release the physicians, other health care professionals, agents, servants, and employees of AHN from any liability whatsoever for lost articles and money that I might keep with me.

CONSOLIDATED PART 2 CONSENT

If applicable, I permit AHN to maintain my records pertaining to treatment of substance use disorder covered by 42 C.F.R. Part 2 ("Part 2 Records") in its electronic health system, Epic, and share my Part 2 Records, including dates of service, name of treating provider(s), and diagnosis, with insurance providers, health plans, and third-party payers for payment and benefits administration. I also permit AHN to disclose my Part 2 Records as needed for treatment, payment, and healthcare operations purposes, including to my other treating providers. I understand that I can revoke this consent any time and that my consent to share this information will continue only as long as necessary for these stated purposes.

CONSENT TO APPEAL

In the event that my insurance company denies payment for any services rendered during this episode of care, I authorize the agents, servants, and employees of AHN to file a grievance for payment on my behalf; I understand that I have the right to rescind my consent to appeal at any time during the appeal process. If I consent to AHN filing a grievance on my behalf, I understand that I will not be able to file my own grievance concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing. This consent shall automatically be rescinded and I may file my own grievance if my health care provider does not file a grievance, or stops grieving my case. I understand that I am not required to agree to such Consent to Appeal and may opt out without affecting my ability to receive services.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the physicians, other health care professionals or AHN for any services furnished to me by that provider of service. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

STATEMENT TO PERMIT PAYMENT OF MEDICAID BENEFITS TO PROVIDER AND PHYSICIANS

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Department of Public Welfare (D.P.W.) or its intermediaries or carriers any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician or hospital/facility services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to D.P.W for payment.

Patient Identification

ASSIGNMENT OF INSURANCE OR PAYOR BENEFITS

I recognize that I am primarily liable for payment for services rendered. In the event that I am entitled to medical care benefits or insurance of any type whatsoever, I hereby assign those benefits and my rights to insurance payment to physicians and AHN and any of its contract health care providers. I authorize physicians and AHN and the appropriate health care providers to apply for benefits and insurance on my behalf for services rendered to me. I certify that the insurance or other coverage benefit information supplied by me is correct, in accordance with applicable AHN, provider or insurance policies or agreements. If my insurance carrier requires pre-authorization for services I will receive, I understand that it is my responsibility to obtain the required pre-authorization. If I fail to do so, I will be liable for all or part of otherwise covered expenses.

ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT OF PHYSICIAN, HOSPITAL, FACILITY BILLS

I guarantee payment of all charges incurred for services rendered by the physicians, other health care professionals, and the facilities of AHN for the patient named on the opposite side of this page. The amount due for non-insurable charges including co-payment, deductibles, and private room fees shall all be paid in full at the time of service. Should my account be referred to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses.

DOCUMENTATION ACKNOWLEDGMENTS

I acknowledge that I have received and reviewed a copy of both the AHN Patient Rights & Responsibilities and the Notice of Privacy Practices (the "Notice"). I understand that information AHN acquires or creates about me will be disclosed to others for treatment, payment and health care operations or other appropriate purposes as set forth in the Notice or as authorized by me in writing.

CONSENT TO PROPER VENUE

I agree that any controversy, dispute, claim or lawsuit for damages arising out of or relating to my care and treatment by any provider or entity of Allegheny Health Network shall be litigated in the county where my care and treatment occurred.

I CERTIFY THAT I HAVE READ THIS FORM OR HAD IT READ TO ME AND UNDERSTAND ITS CONTENTS.

THIS CONSENT TO TREATMENT, RELEASE AND ACKNOWLEDGEMENT FORM WILL REMAIN IN EFFECT FOR A PERIOD OF ONE YEAR UNLESS I DECIDE TO REVOKE IT.

Signature _____ Date_____Time_____

❑ Patient ❑ Substitute Decision Maker

Signature of Witness _____ Date_____Time_____

If Substitute Decision Maker, state relationship and reason:

_____

Patient Identification

Allegheny Health Network

201016

Consent to Treatment, Release and Acknowledgement