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_______Initials

RELEASE OF INFORMATION: The George Washington University Hospital is authorized to release any information necessary, including copies of my hospital and medical records, to process payment claims for health care services which have been provided, and to duly authorized local and federal regulatory agencies and accrediting bodies as required or permitted by law. George Washington University Hospital is further authorized to release demographic information to organizations performing patient satisfaction surveys. Such records may include information of a psychological or psychiatric nature, pertaining to my mental condition or treatment for conditions relating to the use of alcohol or drugs. In addition, I authorize my insurance carrier, employer or person otherwise responsible for payment to provide The George Washington University Hospital information necessary to determine benefits or process a claim. This release will be valid for the period of time to process the claim or until consent is revoked by myself. I release and forever discharge The George Washington University Hospital, its employees and agents, and my attending physician from any liability resulting from the release of my medical records or information from them for payment purposes. I understand that my name will be displayed in the signage system outside my hospital room.

PERSONAL VALUABLES: THE GEORGE WASHINGTON UNIVERSITY HOSPITAL WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO CLOTHES, PERSONAL PROPERTY OR VALUABLES.

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I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information that I submit is subject to verification, including credit agency scoring, and subject to review by federal and/or state agencies and other as required, I authorize my employer to release to The George Washington University Hospital proof of my income. I understand that if any information I have given proves to be untrue, The George Washington University Hospital will re-evaluate my financial status and take whatever action becomes appropriate. I acknowledge by my signature that I have read and received a copy of this statement. I understand that by signing it, I am agreeing to it.

X ________________________________
Signature of patient or responsible party

Unable to sign
( ) Serious Condition
( ) ________________

_____ ________________________ Date Witness

________________________________ Hospital Representative

_________ Date

Section 1:

Did you bring an Advance Directive (Living Will/Health Care Power of Attorney) **form with you?**

☐ Yes ☐ No

(If YES, place a copy in the front of the patient's chart / ***If NO, go to Section 2)***

Section 2:

1. I was given information on formulating an Advance Directive (including how to obtain assistance with completing the Advance Directive form). ______**initials**

OR

2. I do not have an Advance Directive and do not wish to formulate one. ______**initials**

By my signature below, I consent to laboratory studies (HIV, HBV, HCV) in the event a health care worker is exposed to my blood or body fluids. I also agree to the disposal or use of any tissue or part removed from my body and/or to the taking of photographs during my treatment for research, teaching, or scientific purposes as long as my identity is not disclosed.

Signature ________________________ Date __________

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

PATIENT AUTHORIZATION FORM

80-010 (7/06)

WHITE - MEDICAL RECORD YELLOW - BUSINESS OFFICE PINK - PATIENT COPY

Patient Label

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Signature of patient or responsible party

Unable to sign
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_____ ________________________ Date Witness

________________________________ Hospital Representative

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THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

CO0010

PATIENT AUTHORIZATION FORM

80-010 (7/06)

Patient Label

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