

Palmetto Health General Consent

All Patients I consent to and authorize Palmetto Health to perform as applicable:

Blood Draws	Medications	Tissues Disposal/Donation
Examinations	Procedures	Treatments
Lab Tests	Therapy	Transportation

These activities may be performed by authorized Palmetto Health or affiliated physicians and/or clinicians, including appropriately supervised students and residents.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION?

My photograph may be taken for identification purposes and is the property of Palmetto Health unless I withdraw my consent in writing. If I have provided my e-mail address, I am requesting the ability to access my medical information through the Palmetto Health on-line Patient Portal.

I give permission to share my electronic medical record among my health providers and obtain medication history through a Provider Health Information Exchange (HIE). Palmetto Health will not provide sensitive information such as behavioral health, substance abuse treatment, sexual abuse, genetic test results, HIV/STD status and adoption records unless mandatory disclosure is required by state or federal law. **I may opt out of the HIE and continue to receive care.**

I provided the following information:

I have requested to not be listed in the Palmetto Health Patient Directory	
I am an organ donor	
I have an Advance Directive	
I would like information about Advance Directives	
I was given a Privacy Practices Notice on	

Hospital Patients Only

If I signed a general consent form at my physician’s office today, it is not necessary to sign another copy.

I understand video cameras may be used in some hospital rooms for observation purposes and additional photographs may be taken for medical purposes.

If I bring money and valuables to the hospital, I am responsible for any loss or damage for items not sent home or deposited with Palmetto Health.

I was shown/provided a copy of the Lewis Blackman Hospital Patient Safety Act Letter. I understand that the Patient Bill of Rights notice is posted in the public lobbies, printed in Patient Guides and available through the hospital’s website @ www.PalmettoHealth.org.

If applicable, I consent to the disposal by Palmetto Health authorities of any tissue or body part which may be removed during the course of my treatment. I further understand if my tissue is used rather than destroyed, it will not be linked to my name or any other identifier that could be traced to me. To protect myself and others, I also give permission to have blood drawn and tested for infectious diseases including, but not limited to, HIV (AIDS virus) and Hepatitis. I further understand that certain circumstances require mandatory disclosure to organizations such as the state health department.

Patient or Patient Designee Representative Date Time

Witness Signature