



Patient Sticker Here

OUTPATIENT GENERAL CONSENT FORM

This consent applies to Indiana University Health Physicians, its agents, associates, as well as providers. In each paragraph IU Health Physicians refers to all IU Health Physicians practices. In each paragraph doctors, independent doctors, residents, fellows, nurse practitioners, and physician assistants will be called providers. I understand that some of the providers who may be involved in my care are not employees of Indiana University Health Physicians.

I agree to let IU Health Physicians, its agents, associates, as well as providers give me medical and surgical care. This includes tests, blood tests, exams, anesthesia, procedures and drugs which are necessary for the diagnosis and treatment of my medical condition according to the judgment of my treating provider.

I agree that IU Health Physicians cannot make any explicit guarantee or promises regarding results or cures.

Teaching Environment: I understand IU Health Physicians is part of a teaching environment and at times I may be asked to allow students, residents and fellows to be involved in my care.

My data such as demographics, lab results, biopsy results, diagnoses may be used for research. The research may or may not be related to my health care. My data will be carefully treated so I cannot be identified, except as required by law.

I understand IU Health Physicians has a commitment to research and on occasion, I may be contacted about participation in a research study and that I have the right to opt out from further contact.

Infectious Disease Testing: I agree to allow IU Health Physicians to test for infectious diseases including hepatitis and human immunodeficiency virus (HIV) if one of my caregivers is exposed to my blood or body fluid. In reciprocity, if I am exposed to any blood or body fluid during my treatment I can request the source person be tested for such infectious diseases in accordance with Universal Protocol; at no cost to parties being tested. All parties involved will have access to results.

Release of Information: I agree to allow my previous health care providers to share my medical records with IU Health Physicians to provide my health care. I agree that, if I am not competent to speak for myself, or if I so request, IU Health Physicians may share my medical information with appropriate family members as minimally necessary to make decisions about my care. I agree that as allowed by law, IU Health Physicians may share my medical records with third-party payors, insurance companies, review agencies, welfare departments, and with third-party data service providers including systems like the Indiana Network for Patient Care (INPC). Patients have the right to opt out, in writing, from this program. This may include records about infectious diseases and drug and alcohol abuse treatment. At any time, I may change my mind about agreeing to this release of information by giving notice to IU Health Physicians in writing.

Health Insurance Portability and Accountability (HIPAA): I acknowledge that I have been offered and/or received the IUHP Notice of Privacy Practices.

Communications: I agree to allow the physician practice, its assignees, and contractors to contact me via automated dialer or recorded message on any telephone number provided to IU Health. I understand I may opt out of receiving calls and text messages at any time.



