# Lewes Surgery Center
# Authorization for Treatment:

Patient Label

**This is to certify** that I, the undersigned, or my authorized Personal Representative hereby consents to and authorizes the administration and the performance of all diagnostic procedures and such medical, surgical, or radiological treatments, which in the judgement of my treating physician or his/her authorized agent, are considered to be medically necessary or advisable. I understand that I have the right to be fully informed as to the facts about my illness or treatment before the beginning of such treatment, surgery, or diagnostic procedures. I acknowledge that there is no guarantee made as a result of any medical interventions.

**I understand** that the Lewes Surgery Center may release all or part of my medical record to any person or agent, who is responsible, under contract or by law, to the Lewes Surgery Center or myself for all or part of the Lewes Surgery Center charges, including but not limited to other providers or medical service companies, Medicare, Medical Assistance, insurance companies, managed care organizations, Worker's Compensation carriers, or any other healthcare reimbursement source. The Lewes Surgery Center may also disclose any information concerning my care, which is necessary for continued medical care, research, accreditation, or to meet regulatory requirements. I have received the Lewes Surgery Center's Notice of Privacy Practices, which outlines the circumstances under which the Lewes Surgery Center may disclose any information concerning my care. I understand that I have the right to read this Notice before signing this authorization.

**I agree** that the Lewes Surgery Center shall **not** be held liable for the loss or damage to any personal articles (including glasses and dentures) retained by me during my outpatient visit.

**I hearby** authorize the Lewes Surgery Center to complete my insurance or healthcare reimbursement forms in connection with my outpatient service and appoint the Lewes Surgery Center as my agent to this end.

**I, the undersigned patient** (or parent, spouse, or Legal Guardian), severally assume the responsibility for all charges for the above named patient and shall pay the same upon demand. If the bill remains unpaid, I also understand that I will be held responsible for **all** collection charges.

**This form has been fully explained to me, and I understand its contents.**

_____ _____ _____ _____
(Signature of Patient) (Date) (Signature of Witness) (Date)

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## Authorized Personal Representative

Fill in this section ONLY if the patient is unable to consent to treatment or is unavailable.

Your name (please print): _____

Relationship to patient (please check):
❑ Legal Guardian ❑ Healthcare Power of Attorney
❑ Spouse ❑ Parent ❑ Adult Child ❑ Adult Sibling ❑ Grandparent
❑ Unrelated caregiver ❑ other: _____

**This form has been fully explained to me, and I understand its contents; and certify that the above checked "relationship" to this patient is correct.**

_____ _____ _____ _____
(Signature of Personal Rep) (Date) (Signature of Witness) (Date)

I have been provided with the Lewes Surgery Center's Notice of Privacy Practices today. _____
Initials