DANA-FARBER CANCER INSTITUTE
GENERAL AND FINANCIAL CONSENT FOR OUTPATIENT MEDICAL SERVICES AND AUTHORIZATION

PATIENT IDENTIFICATION

Name of Patient _____

DEFINITION OF DANA-FARBER CANCER INSTITUTE. In this consent form, "Dana-Farber Cancer Institute" (also called "DFCI" or "Dana-Farber") means Dana-Farber Cancer Institute, Inc. and members of its medical staff, health care professionals, employees and agents of DFCI, and all affiliated physicians, health care professionals and health care entities associated with DFCI.

I. CONSENT FOR DIAGNOSIS, CARE AND TREATMENT. I authorize DFCI healthcare professionals who are involved in my care to examine me and provide diagnosis, care and treatment. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me about the result of my examination or treatment at DFCI. I authorize DFCI to use, store, and dispose of any tissue, fluids or specimens that may be removed from my body during my visit.

II. ACCESS TO HEALTH INFORMATION. I understand that DFCI will keep records that contain my medical, personal and other information related to my diagnosis, care and treatment in electronic, paper, and other forms. My personal and medical information will be used for the purpose of treatment, to obtain payment for services and supplies, and to support healthcare operations. I authorize DFCI physicians and other health care professionals who are involved in my care to contact other physicians, healthcare professionals, hospitals, nursing homes, home health agencies, pharmacies and other healthcare providers to obtain from such providers information relevant to my prior and current health conditions. I further authorize my DFCI physicians and other health care professionals who are involved in my care to disclose information about my diagnosis and treatment for purposes of coordination and continuity of my medical care. If I visit a DFCI satellite site (in Jamaica Plain, MA; Milford, MA; Weymouth, MA; or Londonderry, NH), I authorize DFCI to make my medical records available to the local hospital with which the satellite site is associated (Faulkner Hospital, Milford Regional Medical Center, South Shore Hospital, or Elliot Hospital, respectively) in order to facilitate the general coordination of care with such hospital.

III. RESPONSIBILITY FOR PAYMENT. I authorize DFCI to bill my insurance plan (be it private health insurance, Medicare, Medicaid, other health insurance program) for all medical, technical and facility services and supplies provided to me. I further authorize DFCI to release any information from my medical record necessary for payment purposes. If my insurance plan or program does not cover all or some amount of the bill, DFCI may bill me for such amounts, and I will be personally responsible to pay for uncovered cost. Examples of costs that may not be covered by insurance are deductibles, co-payments and costs of services not covered by my health insurance or programs for which I am eligible. I understand any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan and my certificate of coverage. If I am uninsured, I agree to assume full financial responsibility for services, facilities and supplies provided to me.

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IV. ASSIGNMENT OF BENEFITS. I hereby assign to DFCI, and to other healthcare professionals involved in my care, if applicable, all my rights and claims for reimbursement under any private or other health insurance plan, including Medicare, Medicaid, or any other programs for which benefits may be available to pay for the hospital and medical services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

V. SPECIFIC CONSENTS AND AUTHORIZATIONS; RIGHT TO REVOKE. I understand that I will have further opportunities to provide consent to treatments and procedures and/or authorizations. I understand that when my specific consent or authorization is required by law, I will have a right to revoke such consent and/or authorization in the manner described in the DFCI Privacy Notice. However, such revocation will not be effective to the extent that DFCI has already acted in reliance on my consent or authorization.

VI. AFFIRMATIONS. This form has been explained to me and I have had an opportunity to have my questions answered. I am satisfied that I understand its contents. I understand that I am free to revoke my written authorization to disclose health information (when authorization is required by law) at any time without prejudice of any kind. I further understand that if I have any questions at any time, a physician, social worker, or patient representative is available to answer them.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I UNDERSTAND THE INFORMATION ABOVE AND HAVE GIVEN MY CONSENT FREELY AND VOLUNTARILY.

Witness _____ Patient's Signature _____

Date: _____ Time: _____

When patient is a minor or incompetent to give consent, signature of person authorized representative:

_____

Relationship to patient: _____