FACILITY DISCLOSURE AND CONSENT

1. **RESPONSIBLE RIDE HOME:** I (we) understand that I am scheduled to go home after my surgery and I must have a responsible adult drive me home and stay with me as advised by my physician.

   I (we) understand the surgery is intended to be performed on an outpatient basis. I consent to my transfer to a hospital or other facility should my physician(s) deem it advisable or necessary.

   I (we) understand the Surgery center is not responsible or liable for the loss of or damage to any article of value that I have brought to this facility.

2. **TISSUE/COMMUNICABLE DISEASES:** I authorize the surgery center to dispose of any specimen or tissue taken from my body during this operation or procedure. In the event any tissue is deemed potentially pathological it will be sent to pathology.

   I (we) understand that Texas law provides and I (we) agree, that if any healthcare worker is exposed to my blood or other bodily fluid, to allow North Austin Surgery center to perform tests on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, hepatitis and human immunodeficiency virus (which is the causative agent of AIDS). I (we) understand that such testing is necessary to protect those who will be caring for me while I am a patient of the Surgery center. I (we) understand that the results of such tests do not become a part of my medical record.

3. **MEDICAL STAFF AFFILIATION:** I (we) understand that each patient is admitted under the care of the patient's attending physician. I (we) understand that although all physicians practicing at North Austin Surgery center are members of North Austin Surgery center medical staff, they are not agents or employees of the facility and are not authorized to make representations on behalf of the facility. Specifically, I (we) understand radiologists, pathologists, anesthesiologists, and all other physicians, are independent contractors and are not agents or employees of North Austin Surgery center. I (we) further understand and agree that North Austin Surgery center is not liable or responsible for the care and treatment rendered to the patient by the physician members of the Surgery center's medical staff.

4. **PHOTOGRAPHING OR VIDEOTAPING:** for the purpose of advancing medical education, I authorize my doctor and/or such associates as he/she may select to photograph or video tape the operation(s) or procedure(s to be performed including appropriate portions of my body, and the inclusion of such pictures in my medical record. I understand that the photographs/ video will be used only for medical and educational purposes and will not be released for publication in any other context without my written permission.

   I (we) consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the center's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the facility without a specific written authorization from me or my legal representative unless otherwise required by law.

5. **PROTECTED HEALTH INFORMATION:** Your physician may provide to you, or upon your request, you may receive your protected health information (PHI) in an unencrypted format. This means that there is some level of risk that a third party could see your PHI without your consent. Because you have requested it in an unencrypted format, North Austin Surgery center is not responsible for unauthorized access to the PHI contained in this format.

PATIENT SIGNATURE

DATE

If the patient is a minor or unable to sign, complete the following:

☐ Patient is a minor. ☐ Patient is unable to sign because _____

Signing on behalf of patient: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Other _____

Parent/Guardian/PDA Signature

Relationship to Patient

Date

PATIENT IDENTIFICATION

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