General Consent to Treatment and Release of Information

Name: ....

HN: .... Date: ....

Birth Date: .... Age: ....

Room: .... Sex: ....

Physician: ....

Allergies: ....

1. General Consent to Treatment: I voluntarily consent to receive diagnostic, medical treatment, and health care services which also include the diagnosis procedure, examination, photographing for medical purpose and medical treatment recommendation provided by Bumrungrad International Hospital (here in after called "The Hospital") physicians, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I acknowledge that the hospital could not guarantee the specific outcomes relating to any treatments, procedures, or other services I will receive from the Hospital.

2. Consent to be photographed: I understand that the registration photograph is a part of my medical record and which is used for identification purposes which will be in my medical record and my electronic medical record. I hereby give my consent to be photographed.

☐ I agree ☐ I do not agree

3. Release and Management of Medical Information: I understand that my medical information and records are kept confidential as indicated in the Hospital's Patient's Bill of Rights.
In agreement,
I agree and consent that the Hospital may disclose all or any part of my medical records as specified in hospital's policy and may provide bill/invoices to:

- ☐ My immediate family members and caregivers/individuals authorized by the law.
- ☐ Referring physicians, hospitals/clinics and medical units.
- ☐ Third party payers for health care services provided to me such as insurance, my employers and/or embassies.
- ☐ Others as specified: ....

I agree to release and hold harmless Bumrungrad Hospital and its agent ,representatives, employees from any and all liability associated with the disclosure of confidential patient information as authorized in this General Consent to Treatment and I do agree that the hospital is not responsible for the use or non-authorized disclosure of information by others to whom I have consented disclosure of my confidential information.

I acknowledge that my medical information, treatment and all its history is kept in medical records and electronic medical record. If I do not received services or treatment from the Hospital for 5 consecutive year, my medical records and other treatment records [including imaging records] may be deleted and/or destroyed.

4. Financial Responsibility and Assignment of Benefits: I agree that I will be personally responsible for payment of all charges for services provided by the Hospital. When accepted by the Hospital, I hearby assign my right, title, and interest in all insurance, or other third-party payer benefits for medical or health care services otherwise payable to me to the Hospital. I also authorize direct payments to be made by my insurance company or other third-party payer, up to the amount of my medical and health care charges, to the Hospital. I certify that the information I have provided in connection with any application for payments by third-party payers, is correct.

I also agree to make payment, as requested by the Hospital for all charges for medical and health care services that are not covered by or which exceed the amount estimated to be paid or actually paid by my insurance company, or other third-party payer.

5. Patient Responsibilities toward Hospital's Policy: I agree that I will comply with the Hospital's policies regarding Patient Responsibilities as well as all Hospital's policies rules and regulations regarding patient and visitor behavior including the Hospital No Smoking Policies.

6. Dispute Resolution Jurisdiction : I hereby agree that jurisdiction and venue for any claim or dispute arising from or in any way related to the diagnosis, examination, medical care services, analysis, photographed, advice and/or treatment by the Hospital, its employees or any physician or clinician with privileges at the Hospital, shall be exclusive and proper in the courts of Thailand. In addition, any such claim or dispute shall be subject exclusively to adjudication pursuant to the laws of Thailand.
I understand that this General Consent will be valid and remain in effect as long as I attend the Hospital unless revoked by me in a written notice to the Authorized officer of the Hospital.
I certify that I have read and understand this General Consent and accept all of its contents.

....	....	....
Signature, Patient	Full Name (Block letters)	Date
....	....	....
( )	ID Number/Passport Number	Relationship to patient
Other Legally authorized person / Patient's representative		
....	....	....
( )	Language used in Translation	( )
Translator		Witness

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