

## GENERAL CONSENT AND AGREEMENT

We have developed the following agreement to ensure a long and healthy relationship together. Please read the following information carefully. After you have read this consent and agreement, please sign your name indicating your acceptance of the terms of this agreement.

- I agree to permit the providers, residents, learners and staff of Hudson Headwaters Health Network (HHHN) to provide medical care to myself, child, or legal ward as applicable.
- I agree to permit laboratory and diagnostic tests, medical treatment (for example, medications, injections, drawing blood for tests, counseling, screening tests, health education and other diagnostic procedures), emergency care as necessary, and hospital services performed at the request of my providers, residents or others assisting in my care. I understand that I have the right to refuse this treatment at any time.
- I understand that my care team may include resident physicians, students, or other trainees. A resident is a doctor who has graduated from medical school and is undergoing further training. I understand that the resident may perform all or parts of my care. I understand that I have the right to refuse this arrangement at any time.
- I understand that a medical record will be prepared and maintained about me by HHHN, and that I am able to view my medical record via the *Patient Portal*. I am also entitled to obtain a copy of my medical record by signing an *Authorization for Release of Health Information* form.
- I agree to abide by HHHN's *Patient Responsibilities* and understand that these responsibilities are posted in all health centers, online, and are physically available to me upon request. I understand that HHHN maintains the right to discontinue treatment for any violation of these responsibilities, such as failure to maintain a consistent appointment schedule or inappropriate behavior. In such cases, the patient or parent/guardian agrees to accept full responsibility for pursuing alternate medical care.
- I understand my provider leverages technological tools and resources including those which leverage artificial intelligence in the delivery of my care.
- I understand that some treatment and procedures may require an additional consent agreement to be completed.
- I understand that this consent is valid as long as I am an active patient of HHHN. I have the right to withdraw my consent at any time. I understand that refusal to sign this consent and agreement may prohibit my ability to access HHHN services.

By signing this document, you understand the agreement and consent in full, and you have had all of your questions answered to your satisfaction.

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Signature of Patient or Representative  
Authorized by Law

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Print Name

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Date