SELF REGIONAL HEALTHCARE

EDGEFIELD MEDICAL CENTER

A Department of
Self Regional Healthcare Partners

Rural Health Consent Form

Authorization to Release Information: I hereby authorize Self Regional Healthcare (SRH) to release information acquired in the course of my medical treatment to my insurance companies. I also authorize payment directly to SRH for medical treatment received and claims submitted on an assigned basis.

I Further Understand and agree that: By signing below, either personally or through the person legally empowered to give consent, I authorize SRH, its employees, agents and other affiliates to provide general care forth is and all subsequent requests for care. SRH shall also be entitled to the recovery of all its expenses, including all collection fees, attorney's fees and other legal costs, that it incurs in connection with the collection or recovery of an unpaid balance on my account and that these costs of collection shall be immediately due and payable upon demand.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? ❑ YES ❑ NO

IF YES, WHOM? _____

Signature: _____ Date: _____