CARE AGREEMENT

This form contains facts you should know about your health care at UW Medicine and from Children's University Medical Group, University of Washington Dentists and Oral Surgeons, and Seattle Cancer Care Alliance. If there is any part of this form that is unclear you can ask questions about it. At the bottom of the form there is a place for you to sign your name so that we know you have read this form (or had it read to you) and agree to receive health care from us.

UW Medicine includes:

- University of Washington Medical Center and Clinics
- Harborview Medical Center and Clinics
- UW Medicine Neighborhood Clinics
- UW Physicians Sports Medicine Clinic
- UW Medicine Eastside Specialty Center
- Hall Health Primary Care Center, and
- UW Physicians

Your healthcare team consists of medical doctors, doctors who have completed medical school but are receiving additional training (residents and fellows), nurses, other healthcare professionals, and other health sciences students (for example, nursing students). They will work together to diagnose and treat you. You will have an attending physician. This is the doctor who has primary responsibility for your care.

Photographs, videotapes, or other images of you may be used to keep a record of your care and treatment (including surgery). These images may become part of your medical record.

SIGNATURE

By signing below, it shows that you have read this document and agree to receive health care from UW Medicine. If there is any part of this form that is unclear, be sure to ask questions about it.

SIGNATURE (PATIENT OR AUTHORIZED REPRESENTATIVE)	**PRINT NAME**	**DATE**

IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:

☐ 1. Guardian ☐ 2. Durable Healthcare Power of Attorney ☐ 3. Spouse/registered domestic partner
☐ 4. Adult Child(ren) ☐ 5. Parent(s) ☐ 6. Adult Brother(s)/sister(s)

FOR MINOR PATIENTS:

☐ 1. Guardian/legal custodian ☐ 2. Court-authorized person for child in out-of-home placement ☐ 3. Parent(s)
☐ 4. Holder of signed authorization from parent(s) ☐ 5. Adult representing self to be a relative responsible for the minor's health

PT.NO

NAME

Place EPIC Label Within Box

DOB

UW Medicine
Harborview Medical Center – UW Medical Center
University of Washington Physicians
Seattle, Washington

CARE AGREEMENT

U0051

UH0051 REV JUL 07

WHITE – MEDICAL RECORD
YELLOW - PATIENT

CONSENT – GRAY