Patient Label

APPENDIX A
Waiver of Liability for Treatment by an External Healthcare Provider

I, _____ a patient at Quinte Health Care, or,

I, _____ a Substitute Decision Maker

for_____, have requested that the therapy described below be provided to me/the patient while a patient admitted to Quinte Health Care.

Description of therapy:

_____

External Healthcare Provider:

_____

I recognize and acknowledge that in the course of providing the therapy at my request the external healthcare provider that I have employed is not an agent or servant of Quinte Health Care (QHC) or a physician or other healthcare practitioner associated with QHC.

I have been informed by _____ (Name of External Healthcare Provider) of the degree and nature of the risks, benefits and side effects of the therapy and have consented to the therapy with the full knowledge of such risks, benefits and side effects. I also assume complete responsibility for the full payment of any fees related to the above named treatment/service. In hiring this provider, I assume full responsibility for any and all risks of this related to my/patient's current health condition.

I understand that there may be unanticipated side effects/symptoms as a result of this therapy, and as possible, that it is my/patient's responsibility to let the physician and other care providers know if any side effects or symptoms occur. If such side effects or symptoms occur, I understand that my/patient's physician may advise or direct the therapy be stopped.

In consideration of QHC permitting such therapy to occur on its premises, I, the undersigned, hereby release, waive and forever discharge QHC and its respective employees, agents, representatives and medical staff from all claims, demands, damages, costs, expenses, defense costs, actions and causes of action, whether in law or equity, in respect to death, injury, loss or damage to my person or property however caused, arising or to arise by reason of my hiring a private service provider.

Patient/Substitute Decision Maker Name (print) **Signature**

Date (DD/MM/YYYY) _____

STAFF INSTRUCTIONS
Please place the original copy of this form on the patient's chart and provide the patient/SDM with a photocopy