



Patient Name:

DOB:

MRN:

**SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER**  
**Patient Supplied Medical Equipment Release**  
**ATTACHMENT "A"**

I, \_\_\_\_\_  
NAME OF PATIENT

use \_\_\_\_\_  
MEDICAL EQUIPMENT MANUFACTURE, EQUIPMENT TYPE, AND MODEL

in my ongoing medical therapy. This equipment is designed for patient operation and maintenance and I have received training in the proper operation and maintenance of this equipment. I presently use this equipment in the treatment of a medical condition. I understand that standard policy at San Francisco General Hospital (SFGH) prohibits use of non-SFGH medical equipment. I have requested that an exception to this policy be made so as to allow me to continue my present treatment. I agree to take full responsibility for the equipment and its proper use. I understand that SFGH medical staff may not be trained in the use and maintenance of this particular medical equipment. Responsibility for the correct use and maintenance lies with me. I agree to take full responsibility for use and maintenance of the above-named equipment while a patient at SFGH. I further agree that SFGH, its healthcare providers, and other employees shall not be responsible or liable for the proper use or maintenance of this equipment.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Physician's Name (Please Print)**

\_\_\_\_\_  
**Physician's Telephone No.**

\_\_\_\_\_  
**Signature of Physician**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Department Nurse Manager or Designee**

\_\_\_\_\_  
**Date**