Patient/Family Informed Consent/Consent for Release of Information

I hereby consent to admission and care by Hospice of Health First, Inc. I acknowledge and consent to the following:

I understand the goal of Hospice of Health First Inc., is not to cure my terminal illness. The program staff and volunteers will work to reduce symptoms such as pain or nausea. Hospice staff will also provide emotional support and spiritual support (when requested) to me and my family and/or other primary care person. These services will be documented in the Plan of Treatment.

I understand that my family and/or primary care person and I will be cared for and visited where the patient resides. I understand that _____ will be my "primary care person". This means that he/she will be the person mainly responsible for looking after me in my home. In the event that a primary care person is not available to provide care, revocation by Hospice of Health First, Inc. may become necessary.

I understand care will be provided to me by the Hospice team. This team includes volunteers, and at times, contracted staff. I understand that as long as I am enrolled in this Hospice program, a Hospice team of caregivers will manage my care whether I am being cared for in my home, in the hospital, or in a nursing home.

I understand that if I am to receive the full benefit of Hospice care it is important for me to make needs and concerns known to the Hospice staff. I will actively participate in the POT for my care. I understand that care will be provided by scheduled appointments, but that assistance is available 24 hours a day. The Hospice number is: 952-0494.

I understand that the Hospice medical record will contain information about me, my family and/or my primary care person. Every effort will be made to keep this information confidential. Additionally, information concerning my care/condition may be shared with my family.

I, authorize Hospice of Health First, Inc. to release information from, or copies of, my Hospice Medical Record and/or to allow review by reimbursement sources; regulatory agencies, accrediting organizations and/or other healthcare providers.

I understand the above information is required for the purpose of obtaining reimbursement for Hospice care provided and allowing continuity of care among health care providers. I am authorizing release of all future medical record documentation relating to my care to those sources named above. This authorization will not be valid once the above named sources have received copies of and/or reviewed my medical record to verify any claim received or payment made to Hospice of Health First, Inc.

I understand the reimbursement sources, regulatory agencies, other healthcare providers, and/or accrediting organizations cannot release to anyone else any information received unless I specifically authorize such a release.

Notice of Privacy Practice Acknowledgment
I have received on this, or a prior occasion, the Health First Notice of Privacy Practice and acknowledge that I have a copy or that I requested, and was given a copy.
Received a copy on this date ❑ Previously received ❑ Unable to obtain a written acknowledgment of receipt
Reason _____

Health First Health Information Exchange
The Health First Information Exchange (HFHIE) grants clinicians participating in your care electronic access to your most up-to-date-medical records. This consent is to establish if you would like to participate in HFHIE.

❑ Opt Out: I do not want my medical records accessed by any healthcare professional throughout HFHIE

❑ Participate: I give consent to allow access to my complete medical records (which may include documented information related to psychiatric records and sexually transmitted diseases, including but not limited to, HIV and AIDS) when medically necessary, to participate throughout the HFHIE. You can change your consent at any time by going to your participating HFHIE provider and requesting a change.

We acknowledge that we have been given ample opportunity to ask any and all questions we have concerning the Hospice program of care and reimbursement for services provided.

Participant's Name | Participant's Signature | Date

Power of Attorney's Signature/Legal Guardian's Signature/Primary Care Giver | Date

I have explained the purpose of the Hospice program of care and the nature of the involvement requested by the participants.
I have answered all questions about the program asked by the patient.

Witness Signature | Date

Health First
Hospice of HEALTH FIRST
Licensed to serve since 1985

1900 Dairy Rd.
West Melbourne, FL 32904
321-952-0494
Fax 321-952-0382
Revised 7/92, 8/98, 2/10,11/12

PATIENT IDENTIFICATION: (PLEASE PRINT)

Name: LAST **FIRST** **MI**

MEDICAL RECORD NUMBER: _____