Freudenthal
HOME HEALTH

PATIENT EMERGENCY FORM/AT RISK CONSENT

With my signature below, I grant the agency above the authority to include my name, address, phone number, medical conditions, physician contact information, and living situation (including caregiver contacts and transportation/evacuation needs) in the Home Health/Hospice At Risk List. This List is designed to keep Emergency Managers in my community aware of my location and special needs in the event of an emergency in my area. Although inclusion in the At Risk List does not guarantee that my transportation needs will be met in an actual emergency, my inclusion in the List provides Emergency Managers awareness of my current health and living situation, as well as the opportunity to more accurately prepare for emergency situations in the area.

I hereby release the home health/hospice agency listed above from all liability under any and all state and federal health care information privacy laws, rules and regulations. I further hereby expressly release, waive, discharge, hold harmless, and covenant not to sue any of the Releases, their employees, agents and officers, from all liability to the undersigned for any and all loss or damage, and any claim or cause of action on account of injury to my person or property or resulting in death, whether caused by the negligence of the Releasees or otherwise.

Patient/Representative Signature: _____ Date: _____

Patient/Representative Name: _____ Date: _____

Relationship to Patient if signing for Patient: _____

Signature of Health Care Representative: _____ Date: _____