PALLIATIVE MEDICINE CONSULTANTS

685 Good Dr.
P.O. Box 4125
Lancaster, PA 17604
(717) 735-3131

Wellspan-York
1001 S. George St.
York, PA 17405
(717) 812-2202 (Outpt.)
(717) 851-3467 (Inpt.)

Wellspan-Ephrata
169 Martin Ave.
Ephrata, PA 17522
(717) 735-3131

PATIENT CONSENT FOR CARE

Your primary physician has asked Palliative Medicine Consultants (PMC) to participate in your medical care. We will collaborate with your primary care physician and any specialist physician(s) who provide your care.

I, ________________________________, understand and agree to the following:

1. Receiving medical services including evaluation, telecommunications technology (also known as "telehealth services"), and recommendations for treatment by PMC.
2. Use of all my health information for treatment, payment, and health care delivery as described in PMC's Notice of Privacy Practices. I have been offered a copy of PMC's Notice of Privacy Practices. I understand that my information is considered confidential and will be treated as confidential by PMC.
3. I understand that I may revoke this consent at any time as long as I do so in writing.

PERMISSION TO RELEASE MEDICAL INFORMATION TO ANOTHER INDIVIDUAL

I give PMC entities permission to release medical information to PMC, and discuss protected health information with the following person(s):

Name	Relationship
Name	**Relationship**

I give PMC entities permission to leave any protected health information on an answering machine or voice mail.

☐ **Yes** ☐ **No**

I give PMC entities permission to mail any office correspondence to the address I have provided ___________
Initials

____
Signature of Patient

____
Palliative Medicine Consultant Representative

____
Name of Patient (printed) Date of Birth

____
Date

____
Patient Representative Signature/Relationship to patient

NOTE: If someone other than the patient signs, please indicate reason patient did not sign.

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