(Home Health/ Hospice Agency Name)

(Address)

(Phone Number)

**At Risk Registry 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 Registry. This registry is designed to keep Emergency Managers

in my county aware of my location and special needs in the event of an emergency in my county. **Although inclusion in the At Risk Registry does not guarantee that my transportation needs will be met in an actual emergency, my inclusion in the Registry 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 county**.

I hereby release the home health/hospice agency listed above, the

Louisiana-Mississippi Hospice and Palliative Care Organization, Secure Computing Systems, Inc. (doing business as “MUMMS”) and Emergency Managers (referred to as “Releasees”) 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 Releasees, 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

Print Patient or Representative Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient if Signing for Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Home Health/Hospice Representative Date