ALLEVIATE HOSPICE CARE INC.
13098 Borden Ave Sylmar, CA 91342
Phone: (818) 433-4558 * Fax: (818) 452-3833
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CONSENT TO PHOTOGRAPH

Patient Name: _____MRN: Date

I hereby consent to the organization taking photographs during the course of my hospice services. The photograph(s) will be for internal purposes (such as quality reviews, education, etc.) to supplement written documentation about my medical conditions, and/or for the payer for my services (Medicare, Medicaid, and/or other insurance) to assist with coverage/payment decisions. I understand that any photographs taken will be placed **in** my clinical • record and that duplicate originals/copies may be forwarded to the payer(s) of my services and/or my physician as determined by the organization.

(Return to Office)

PATIENT NAME: _____DATE: _____

SIGNATURE: _____

HOSPICE REPRESENTATIVE: _____