Waipuna HOSPICE

CONSENT FORM - PRIORITY CONTACTS
Family/Whānau

This form is to be completed by the Priority Contact

I, (Priority Contact Name): ____________________understand and agree to be the first point of contact if we are unable to contact the patient. Please note private patient information will not be disclosed without appropriate authorization from the patient.

As part of our service, Waipuna Hospice may share information with you via email, phone or post, regarding follow up care for family/whānau and on future events, fundraising and newsletters.

There is an opportunity to unsubscribe at any time.

☐ I want to opt-out from receiving information on follow up care for family/whānau.

☐ I want to opt-out from receiving information on events, fundraising and newsletters.

Patient Name:__________________________________

Relationship to Patient: ___________________________

Your Details:

Name (Priority Contact): _____________________________________

Phone Number: ______________________________

Email Address: _______________________________

Postal Address: ____

Signature: ____________________________________ **Date:** __________________

Privacy Commitment

Waipuna Hospice follows the Privacy Act 1993 and the Health Information Privacy Code 1994. We protect your personal and health information.