Health Network General Consent

Fòma de konsantrasyon jeneral

Mwen **/I** _____ _____

Non paysan **/ Name of patient** *Dat nesans* **/ Date of birth**

Mwen bay konsantman mwen pou Health Network mande, resevwa epi voye dosye medikal mwen bay nenpòt founisè medikal pou tan mwen bezwen atansyon. Mwen konprann ke nenpòt moman, si mwen pa bezwen asistans ankò, mwen ka sispann patisipe san sa pa afekte sèvis swen sante mwen resevwa yo. / **I give my consent for Health Network to request, receive and send my medical records to any medical provider for the time I need attention. I understand that at any moment, if I no longer need assistance, I can stop participating without it affecting the health care services I receive.**

_____ _____

Siyati / **Signature** Dat siyati / **Date of Signature**

_____

Dat ekspirasyon / **Expiration Date**

_____ _____

Siyati nan Temwen / **Signature of Witness** Dat siyati /**Signature of Witnessing**

Yon moun kontak Ozetazini ak Health Network kapab kominike ki moun ap toujou konnen kote pasyan an / **A contact person in the United States with whom Health Network can communicate who will always know the patient's location.**

_____ _____

Non kontak **/ Name of contact** *Telefòn # oswa imèl/* **Phone # or email**

* Pou fòm konsantman sa a ka valab, yo dwe mete tout enfòmasyon yo mande yo / **So that this consent form can be valid, all requested information must be included.**

Pou founisè swen sante a **/ For the health care provider.**

Medical reason to request continuity of care support from Health Network:

Health care services required by the patient:

<u>Please attach all medical records (screening results, hospital discharge plans, lab results) to this consent.</u>