CHRISTIANA CARE

CNSNT

**PERMISSION FOR SHARED GROUP MEDICAL VISIT**

I, _____ , agree to participate in Shared Group Medical Visits with my healthcare
(Patient Name)
provider and other patients.

- I understand that Shared Group Medical Visits are meant to add to my individual care and, during group visits, I will meet with a group of patients and their support persons as well as my health care provider.
- I understand that I do not have to participate in the group visit to be treated by my healthcare provider. I understand that I have the option to be seen by my health care provider individually rather than in a group visit.
- I understand that it is likely that some of my health information will be shared with other patients and support persons during the group visit. This information may include, but is not limited to, my medical conditions, results of blood work or tests, medicines and other treatments, and food diaries.
- I understand that, during group visits, I may learn the health information of other patients. I agree that I will keep the information private. If I do not, I understand that I may be asked to leave the group.
- Christiana Care will get each patient's agreement to keep information private. I understand that once my information is shared in a group visit, Christiana Care is unable to keep the information from being shared by the other patients and support persons.

I certify that I have read the above statements, or they were read to me, and I understand them. In addition, I have been offered the opportunity to ask any questions I have regarding the Shared Medical Group Visit. My questions have been answered to my satisfaction.

| _____ | _____ | ___/___/___ | _____ |
|---|---|---|---|
| Patient Signature | Patient Print Name | Date | Time |
| _____ | _____ | ___/___/___ | _____ |
| Witness Signature | Witness Print Name | Date | Time |

**Interpretation:** The information has been presented to the: ☐ patient ☐ representative ☐ decision maker in: _____
Language
The person who provided the interpretation is a qualified medical interpreter.

| _____ | _____ | | |
|---|---|---|---|
| Interpreter Name | Agency and ID# (if applicable) | | |
| _____ | _____ | ___/___/___ | _____ |
| Witness Signature | Print Name | Date | Time |