AUTHORIZATION TO DISCLOSE PROTECTED HEALTH AND OTHER PERSONAL INFORMATION

Client Information

Full Client Name (First, Middle, Last): _____

Date of Birth: _____ Address: _____

Release Information To and Obtain Information From

I hereby authorize_____(Care Coordination Agency) to release personal and/or health information to, obtain from, and exchange with the following necessary to coordinate my care:

- ***Lake County Community Hub***
- **Lake County Contiumn of Care Coordinated Entry/Homeless Management Information System**
- The ***California*** Health Care Services as well as any of my past, present or future Medicaid Managed Care Plans (*Partnership Health Plan and ALL payors contracted with Medi-Cal to provide Managed Medicaid insurance plans).*
- Any current health care providers (including any school nurses)
- Any community social service provider who is or may be involved in my care and maintenance (Social Services, VA).

Information to be Released

As necessary to coordinate my care, the following information may be released to the parties listed above:

- Personal Information (i.e. name, DOB, address, phone number) for purposes of connecting to a community and housing resources
- Medical Insurance Information
- Current Treatment / Housing Plan
- Medical Record information pertinent to my participation in ***Lake County Community Hub*** *(Does not include HIV/AIDS Testing, Drug and Alcohol Information, or Mental Health Treatment information. To authorize the disclosure of such information, you must also INITIAL below)*

Communication

Text/Email: You may ask us to communicate with you by regular text messaging or email which is not secured by a technical process called encryption. That means there may be some level of risk that the information in the text message or email could be read by someone besides you. If you want us to communicate with you by regular text messaging or email, please complete the following:

____ Yes - Communicate with me by regular (unencrypted) text messaging. My cell number is: _____

____ Yes - Communicate with me by regular (unencrypted) email. My email address is: _____

____ No - Please do not communicate with me by regular (unencrypted) text messaging or email.

Purpose and Expiration

By signing below, I authorize the parties designated above to freely exchange the information noted above for purposes of care coordination and related services provided to me. This authorization for the release/exchange of information will automatically expire three (3) years after the date of the authorization unless I agree to a shorter or longer authorization period as noted below.

Condition, date or event of earlier/later expiration: _____

- I understand that if the recipient of the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such recipient and will likely no longer be protected by federal privacy regulations. I understand that ***Lake County Community Hub*** cannot control the recipient's use of the disclosed information.
- I understand that I can revoke this authorization at any time, except to the extent that action has been taken by ***Lake County Community Hub,*** the Care Coordination Agency specified above, or my Medicaid provider in reliance on this authorization, by sending a written revocation to ***Lake County Community Hub.*** Upon revocation of this authorization, further release and exchange of information shall immediately cease.
- I understand that authorizing the use or disclosure of the above information is voluntary. However, by refusing to sign this authorization, I am no longer eligible to participate in the ***Lake County Community Hub*** program.

_____ _____

Signature of Client (or Legally Authorized Representative) Relationship of Authorized Representative (if applicable)

_____ _____

Community Health Worker/ Navigator Signature Date Signed