AUTHORIZATION FOR THE USE AND DISCLOSURE

The North Coast Care Connect (Care Connect) is a partnership of health, social, and community services organizations that help you get services, work with you to understand your needs, and connect you to resources that can help you. Your permission is needed to allow sharing of your protected health information, education records including personally identifiable information, and other personal information, including through electronic systems used by North Coast Health Improvement and Information Network (NCHIIN) and participating organizations. Granting permission allows your providers to communicate better with each other to provide you better care. If you agree, your information will be stored and shared with (to and from) the following types of organizations to help the coordination of your care, resources, and human services

- Health care providers
- Behavioral health providers
- Social services providers
- Health plans
- Housing providers
- Organizations involved with the justice system
- Educational agencies/institutions
- Community organizations, for example, food banks, legal services
- County Departments, for example, The Department of Health and Human Services
- Wellness and other

A current list of Participants, which may change from time-to-time, can be found at the Care Connect information page: https://www.nchiin.org/cie-clients/

By signing this form, you are giving permission for your information including information disclosed and re-disclosed by you and your family, to be shared with (to and from) the types of organizations shown above. It will be used to see if you are eligible for resources and programs from organizations in Humboldt County, help link you to them, and help coordinate between them to better serve you and improve your health. It also makes it easier for your providers to coordinate your care, receive payment for services, conduct program work, and improve the quality of services. For more information on how Care Connect uses and protects your information, and how to get a copy of this Authorization for your records, please view the Care Connect information page.

Signing this form is your choice. No matter what you choose, it will not change your ability to receive services.

AUTHORIZATION FOR THE USE AND DISCLOSURE

By signing my name below, I agree that my current, past, and future treating providers and organizations may disclose my health and/or, social services information, treatment and services records, education records, and other data to NCHIIN and that such data may be shared among and between the North Coast Care Connect participating organizations.

- Information that may be shared will include but not be limited to information about:
  - my personal characteristics (including date of birth, housing status, and contact information),
  - my medical history, mental or physical condition,
  - my social service information (including CalFresh, General Relief, CalWorks, Cash Assistance Program for Immigrants, Medi-Cal, and other public benefits that I may apply for),
  - information from education / school records (including attendance records, transcripts, student health information), and
  - treatment and services I receive.

- I understand that this Authorization will apply to data from all services I receive from Care Connect providers and partners.

I specifically authorize my current, past, and future treating providers and organizations, NCHIIN, and Care Connect participating organizations to share the following information (*check as appropriate*):

☐ Mental health treatment information (excluding psychotherapy notes)

_____(*initial*)

☐ Information about my HIV/AIDS test results _____(*initial*)

I understand:

- This authorization will remain in effect for a period of one (1) year from the date this is signed, or until I change or revoke my authorization in writing.
- I have the right to cancel or change this authorization at any time. I can start this process by talking with any of my Care Connect providers. (A verbal or written notice to revoke your consent will be processed within five business days.) At that time, I will either cancel my authorization or complete a new authorization to reflect the change(s) to the sensitive

information that I want to share. If I limit my information sharing, my sensitive information will not be shared with partnering providers or organizations from that date forward. Any sensitive information previously shared with current or past treating providers cannot be recalled. Should I elect not to share any sensitive information, I may receive limited care coordination services through the North Coast Care Connect system but this will not affect services from the providers.

- When my information is shared, there is a chance it will be re-shared with others. Federal law or California privacy law may not protect the re-sharing of my information.
- I have the right to:
    - Inspect or obtain a copy of my health information and social services information that is shared by this authorization
    - Refuse to sign this authorization
    - Receive a copy of this authorization

I have read this authorization or my provider has read it to me. I authorize the use and sharing of my health and social services information as described above.

Client Signature Date

(Print first name, middle name and last name of individual)

Date Authorization and Consent Expires_____

If this Authorization is signed by a person other than the client, please indicate the relationship:

Relationship to Client

Name Date