North Sound ACH
BUILDING HEALTHIER COMMUNITIES
in Island, San Juan, Snohomish, Skagit & Whatcom Counties

North Sound Pathways Community Hub Participation and Release of Information Consent

1. PARTICIPANT INFORMATION:

First Name Last Name

Address (Number, Street name, Unit/Apt #) City State ZIP

Phone/Email:

Please print clearly

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2. I ____________________________ agree to participate in the North Sound Accountable Communities
print participant name
of Health Pathways Community Hub program. I understand that the purpose of this project is to provide me with a care coordinator who will help me get the best care to manage my health conditions in order to improve my health and the health of my family members.

3. I AUTHORIZE INFORMATION TO BE RELEASED TO / EXCHANGED WITH:

ENTITIES AUTHORIZED TO RECEIVE, AND USE PROTECTED HEALTH INFORMATION:
(List the name of the Provider, Organization, Lead Coordinator and Date of Consent)

Organization and lead contact	Date	Initials

4. PARTICIPANT: For the above-named individual, the North Sound Pathways Community Hub is authorized to (initial each permission):

	Release of information to entities authorized
	Exchange of information with entities authorized
	Obtain verbal or written information from entities authorized

5. RELEASE AND USE OF PROTECTED HEALTH INFORMATION

As a participant in the Pathways Community Hub Project, I authorize the release and use of all of the following protected health information EXCEPT:

DISCLOSURE EXCLUSIONS TO RELEASE OF PROTECTED HEALTH INFORMATION: (List exceptions, provide date and initials)		
Exception/exclusion	Date	Initials

6. PURPOSE OF RELEASE

The information I have authorized for release is to be used only for the purposes of the Pathways Community Hub Project. I understand these uses are:

- To ensure I am eligible to participate in the program
- To have the opportunity to review and understand the contents of this form
- To find out what services I may need/ benefit from my care coordinator and from community organizations
- To help program workers get information from my primary care provider so they can organize my health care plans and other services
- To use medical data for outcome evaluation to determine the effectiveness of the program

7. EXPIRATION OF RELEASE

By signing this form, I have read, understand and agree to the information listed, and that this authorization will expire one year from my date of consent, or when I leave the program. I understand that this is a voluntary program, and I may withdraw at any time. My withdrawal from the program will not affect my ability to access medical or other services from any Hub service providers.

I also understand that:

- If I want to participate the in the Pathways Community Hub Project, I must sign this form
- I am not required to sign this authorization form in order to receive treatment, imbursement, or to enroll or be eligible for benefits
- My health care provisions will not be affected if I refuse to sign
- I understand that I, the recipient, receiving this information may re-disclose this information. When re-disclosed, the information may no longer be protected by Federal privacy regulations.
- A copy of this authorization may be used with the same effectiveness as the original form.

8. SIGNATURES

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Signature of Participant or Legal Representative	Date	Time

Print name of Participant or Legal Representative	Relationship of Legal Representative to Participant

Signature of Witness (optional)	Print name of witness (optional)

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