District Health Department #10 HUB
Grand Traverse Regional HUB
Northwest Michigan HUB

Community Connections / Community Healthcare Access Program Consent to Release Protected Health Information

Federal law protects a person's health information. This includes all information that Community Connections collects, including:

1. Health screening and assessment information.
2. Other information you may provide.
3. Information that another party provides.

We may need to share health information with a person's health care provider or other health and social services agencies to help them get connected to resources to help a person or their family. Consent must occur before we can exchange information with any other party. The only exception is when the law requires us to do so. All health information is kept in a confidential record.

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I authorize ____ (Community Connections agency) to exchange health information for ____ with other parties as specified below:

Name of Primary Care Provider	Date	Initialed by client
Name of Other Parties with whom information may be exchanged	**Date**	**Initialed by client**

1. I understand that this may include information about behavioral or mental health services, and referral and treatment for alcohol or drug abuse (as permitted by MCL 330.1748, PA 258 of 1974 and 42 CFR, Part 2)

2. I understand that:
   a. Consenting to the exchange of this health information is voluntary.
   b. I may refuse to sign this consent
   c. My refusal to sign will not affect participation in Community Connections or any insurance benefits.

3. I understand that if I give my consent:
    a. I have the right to change my mind and cancel it at any time.
    b. I will give written notice to my Community Connections agency that maintains my record if I decide to cancel it.

4. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy laws.

5. I understand that any releases already made with my consent, cannot be taken back.

6. I understand that I may request a copy of the signed consent.

7. I understand that this consent will expire at the end of Community Connection services, unless I cancel it before then.

I have read the above, or it has been read and explained to me.

I understand that Community Connection services may be provided without consenting to release protected health information.

_____ I DO consent to the release of protected health information as specified in this form.

_____ I DO NOT consent to the release of protected health information as specified in this form.

____ ____

Client Name (PRINT) Legal Representative name if applicable (PRINT)

____

Legal Representative Relationship to Client

____ ______________________________________

Signature of Client or Legal Representative Date

____ ______________________________________

Signature of Community Connections RN, SW or CHW Date