

**Partners in Health Network, Inc.  
Community Access Program  
Authorization to Use and Disclose Health Information**

(Put your clinic name here)

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**Patient Name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

**Persons/Organizations Receiving the Information:** Partners in Health Network, Camcare Health Education and Research Institute

**Specific Description of Information:** Patient demographic information and clinical data regarding any of the chronic illnesses (diabetes, asthma, hypertension, depression) that are being monitored by the Partners in Health Network Community Access Program, funded by the BPHC, during the grant program period.

**What is the purpose of the use or disclosure:** Partners In Health Network and the designated business associates working on this project will be the only group(s) reviewing "protected health information" as it relates to the CAP grant program. Information disclosed includes case management activities of patients with diabetes, asthma, hypertension and depression. Other clinical health information will be evaluated as de-identified information and will be compared to national standards of care regarding diabetes, asthma, hypertension and depression. Partners In Health Network providers will receive feed-back information regarding individual compliance to standards of care as well as population-based information regarding compliance to standards of care.

**Specific Acknowledgments**

- I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
- I understand that I may see or copy the health information described on this form, if I ask for it, and that I will receive a copy of this form after I sign it.
- I understand that this authorization will expire on termination of the grant program.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not affect any disclosures prior to the receipt of the revocation.

*I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.*

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

Or By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient's Representative)