HEP HEPATITIS EDUCATION PROJECT

HEPATITIS EDUCATION PROJECT
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

TO: Hepatitis Education Project
1621 S Jackson St. #201
Seattle, WA 98144

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I. Information About the Disclosure of My Protected Health Information

As the person who is the subject of protected health information I, _____, request and authorize the Hepatitis Education Project to disclose my protected health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information. Unless revoked earlier, this authorization will remain valid for six years from the last date on which your Protected Health Information is disclosed hereunder.

Protected Health Information to be disclosed (including date(s) of relevant treatment): _____

_____

_____

Purpose of disclosure of my Protected Health Information: _____

_____

_____

Persons/Organizations or Categories of Persons/Organizations authorized to receive my Protected Health Information:

_____

_____

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- This authorization is voluntary, I am not required to sign this form, and I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for any benefits or enrollment, treatment, or payment for or coverage of services.
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party, but any obligations related to or liability for violations of such assurances will remain the sole responsibility of the above-named persons/organizations providing such assurances.
- A copy, facsimile, or electronically transmitted version of this signed Authorization may be treated as valid for all purposes related to this form.

III. Signature of Participant or Participant's Representative

_____ _____

Signature of Patient or Participant's representative **Date**
(Form MUST be completed before signing.)

Printed name of Participant's personal representative: _____

Relationship to the Participant, including authority for status as representative: _____

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CONSENT FOR SERVICES

CONSENT FOR SERVICES

I request services from a Care Coordinator at Hepatitis Education Project (HEP). I agree to participate in the planning, implementation, and ongoing meetings necessary to develop services to address my specific needs. *I understand that I am responsible for staying in contact with my care coordinator, including providing updated contact information, at least monthly. I agree to keep my case manager updated about starting or finishing treatment, as well as the results of post treatment lab work.*

I further understand that if my case manager has made three failed attempts to contact me, my case may be closed. I am welcome to re-join the medical case management program at HEP at any time.

I understand that the Hepatitis C Care Coordination Program keeps records of services provided to me. This record may contain important health information, including hepatitis C diagnoses. This information is confidential and protected by law. Information from my record may not be disclosed to others without my written permission, except under the following circumstances: when you tell us that you will harm yourself, another person, or you will harm or have harmed a child. Additionally program funders may have access to these records when auditing for completeness and accuracy. I may ask to see, copy, and/or correct my record.

I understand that this is a medical case management program, which will focus on elements of my medical care related to hepatitis C. My case manager will be responsible for:

- Finding me a site for ultra sound, liver biopsy, and other hepatitis-related testing services
- Determining my eligibility for medical insurance & help with related paperwork
- Answering my financial questions related to medical care
- Educating me about my medical treatment and plan
- Linking me to agencies that provide medical treatment
- Any additional help regarding my hepatitis C medical care/treatment

My case manager is NOT responsible for non-medical related services, such as housing, food, legal, mental health and substance abuse services. Should I need additional non-medical services, my case manager will provide me with referrals to other agencies that provide such social services.

I understand that the information provided by my case manager at HEP is not a substitute for advice given by my physician or health care provider.

By signing this form, I acknowledge that I have read and understood the above information, and I agree to participate in the medical case management program provided by **Hepatitis Education Project**. I understand that I may withdraw from services at any time and my continued cooperation is important in maintaining my ability to receive services.

_____

Client Signature Date (MM/DD/YR)

_____

Case Manager Signature Date (MM/DD/YR)

Copy of this form given to client on _____ by _____ Form updated 01.26.22

HEP HEPATITIS EDUCATION PROJECT

HEPATITIS EDUCATION PROJECT
CLIENT'S RIGHTS AND RESPONSIBILITIES

At **Hepatitis Education Project (HEP)**, all of our clients have the right to:

1. Be treated with respect, including being free of discrimination for any reason
2. Confidentiality of your records
    a. Confidentiality ***MAY* be broken** by HEP if one or more of the following occurs:
        i. Threats of harm to others
        ii. Threats of harm to oneself
        iii. Reports are made of child or elder abuse
3. Receive services in a setting most comfortable and convenient for you
4. Receive information about your medical condition and/or status, including information about possible treatment options
5. Receive information about available community services including referrals to these services when available
6. Refuse any service, or treatment
7. Participate in the development of your own treatment plan
8. Review copies of your records that are maintained by HEP
    a. HEP is obligated to follow disclosure procedures for records not maintained specifically by HEP (this includes some medical records, mental health records etc.)
9. Be informed about the reasons for refusal or discharge from services
10. File a grievance should you feel these rights have been violated

_____ _____

Client Date

_____ _____

Case Manager Date

Form updated 01.26.22