PATIENT AUTHORIZATION EXPLANATION

IMPORTANT INFORMATION ABOUT THIS FORM

This health care organization is a member of the CapitalCare Collaborative (CCC). The CCC is a group of organizations working together to improve the health of the region's medically underserved. CCC member organizations want people in Wake County to have quality health care services, regardless of their ability to pay. The current members of the CCC, who we refer to as "Participating Providers," include the following:

- Alliance Medical Ministry
- Duke Raleigh Hospital
- Rex Healthcare
- Urban Ministries of Wake County Open Door Clinic
- Wake County Human Services
- Wake Co. Medical Society (including Project Access and Community Care of NC)
- Wake Health Services, Inc.
- WakeMed Health & Hospitals
- Shepherd's Care Medical Clinic
- Mariam Clinic

Additional Participating Providers may be added to the CCC in the future.

All CCC Participating Providers are linked by a computer database that allows them to collect information about patients and their treatment, and share this information, confidentially and securely, with other CCC Participating Providers who treat those patients. Participating Providers and the staff involved in your care are authorized to access your health records to provide and coordinate your health care. In addition, Participating Providers, CCC, and their employees, agents and business associates will be provided the minimum necessary information to permit them to determine your eligibility for Medicaid, Prescription Assistance Programs, and other community or public services; to run their businesses and improve their services to patients; and to offer other community-related services.

Sharing information about you helps your health care providers offer better care.

- They can better understand your health history. That helps them make a more informed diagnosis for better treatment of diseases.
- It prevents them from giving you duplicate tests or medicines that you may not need.
- It may help to qualify you for discounts on prescription medicines.

Your information will not be shared unless you sign the authorization form. These providers cannot condition your treatment on whether you sign this form.

Please read this form carefully, and ask questions if you do not understand it. The form describes what confidential information can be shared, who can see it, and what your rights are with regard to your confidential information that is shared, including how to cancel your authorization.

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Patient Authorization to Share Personal and Health Information

I give permission to the CapitalCare Collaborative (CCC) and its Participating Providers, their employees, agents and business associates to share information about my health, medical treatment and finances. The current list of CCC Participating Providers is attached to this form (Attachment A).

Examples of Information to be Shared:

- Patient name, address, telephone number, email, gender, age, birth date, racial/ethnic background, Social Security number, immunization history, allergies, and emergency contacts.
- Diagnosis of diseases and medical conditions, including but not limited to:
  - mental illness (excluding psychotherapy notes);
  - substance abuse;
  - addiction;
  - HIV/AIDS;
  - communicable and sexually transmitted diseases;
  - tuberculosis;
  - pregnancy and termination of pregnancy.
- Record of physicians, hospitals, clinics and facilities where patient received treatment, now or previously.
- Record of medical treatment, hospitalization, surgery, diagnostic procedures (laboratory tests, x-rays, scans, etc.), prescribed medications, medical devices and related services.
- Information regarding patient's income, insurance status, eligibility for public assistance programs, benefit or insurance claims and other financial information.

Why Health and Other Records Are Shared

Through the CCC, authorized health care providers and staff have immediate access to a patient's health record when there is a need for information. Seeing the patient's health history can eliminate unnecessary tests and referrals, and it informs providers about the patient's allergies, health-related conditions, and medications. Reports of recent care help providers know where, when and why the patient received treatment and whether the patient should receive additional tests or care. The shared record also provides consolidated information on the patient's eligibility for, and benefits from, public health care programs and community services. Signing this authorization form also would permit the CCC to contact public programs and community service organizations, on behalf of the patient, disclosing only the minimum amount of information necessary, for services which are related to health care needs, such as community health planning and providing feedback to Participating Providers on how they are performing against CCC goals.

Patients Choose to Participate

Your provider will ask you to sign this authorization form to have your information included in the CCC database. If you sign the form, it is valid for two years. **Your decision about whether to participate in the CCC database is completely VOLUNTARY. No Participating Provider may condition your treatment on whether you sign this form.** If you do not sign the form, Participating Providers will not share your information through the database with each other unless you give authorization for them to do so at a later time. You may cancel your authorization at any time by completing the Cancellation Form, which you can get from any Participating Provider. Cancellation does not affect information already shared and is effective only after the CCC receives a properly completed Cancellation Form and deactivates the information in the database.

Security & Privacy of Information

Federal and state laws require health care providers to protect the privacy and security of patient information. The CCC will use and maintain appropriate safeguards to protect information in the database. Patients will receive the Participating Providers' HIPAA Notice of Privacy Practices, where applicable, which provides additional information about the providers' respective confidentiality policies. Information disclosed to Participating Providers based on this Authorization may be re-disclosed in accordance with applicable privacy laws.

Patient Authorization

- I understand that by signing this form, I give permission for all current and future CCC Participating Providers, and their employees and agents and business associates involved in my care, to see my personal health and financial records in the CCC database. Providers may see this information even if they are not my usual provider and they do not have my past medical records.
- I understand that my health information could include medical history or information regarding first time diagnosis or treatment of me for a communicable disease (such as sexually transmitted diseases, HIV/AIDS, tuberculosis or hepatitis), mental illness, alcohol and substance abuse.
- A Participating Provider may obtain information about past health care services I received at other CCC Participating Providers.
- I have reviewed the list of current CCC Participating Providers (Attachment A), and I understand that others may be added in the future.
- I acknowledge I have received a copy of this authorization.
- I understand that this authorization will be effective unless and until I appropriately cancel it or the CCC stops doing business.
- I understand that I have the right to cancel this authorization at any time by completing a Cancellation Form, which I can get from any Participating Provider. Cancellation does not affect information already shared and is effective only after the CCC receives a properly completed Cancellation Form and deactivates the information in the database.
- I understand that if I sign as a representative of a patient, I am certifying that I have authority under North Carolina law to make health care decisions for the patient.
- I understand that although my signature on this form permits CCC Participating Providers involved in my care to share my health and financial information, no Participating Provider may access my information in the database unless I go to that Participating Provider for treatment, and unless information about my past health care treatment has already been entered into the CCC database.
- **I understand that my decision about whether to participate in the CCC is completely VOLUNTARY and that no Participating Provider may condition my treatment on whether I sign this form. If I do not sign the form, CCC Participating Providers will not share my information with each other unless I give authorization for them to do so at a later time.**

My signature below indicates my authorization to have my health and financial information entered into the CCC database and shared with current and future CCC Participating Providers and their business associates.

Patient Name (PRINT) _____

_____ _____

Signature of Patient or Authorized Representative | Relationship to Patient (if applicable)

Facility: _____ DOB: _____

Witness _____ Date _____

02/24/10

Attachment A

Current Participating Providers of the CapitalCare Collaborative are:

- Alliance Medical Ministry
- Duke Raleigh Hospital
- Rex Healthcare
- Urban Ministries of Wake County, Open Door Clinic
- Wake County Human Services
- Wake Co. Medical Society (including Project Access and Community Care of NC)
- Wake Health Services, Inc.
- WakeMed Health & Hospitals
- Shepherd's Care Medical Clinic
- Mariam Clinic

Cancellation of Patient Authorization to Share Health Information

I, _____, cancel my authorization given to _____, and its employees and agents, to share my health and/or financial information with other Participating Providers in the CapitalCare Collaborative (CCC).

I understand that cancellation does not affect information already shared and that it will take at least 10 days to deactivate the shared information in the database.

Patient Name (PRINT) _____

Patient Signature _____

Authorized Signer (if not Patient) _____

Signer's Relationship to Patient _____

Facility: _____

DOB: _____

Witness _____ Date _____

Patients should complete this form at a Participating Provider's office. The Participating Provider will give the patient a copy and will then mail the signed form to:

CapitalCare Collaborative
Cancellation Form
2500 Blue Ridge Road, Suite 330
Raleigh, NC 27607