



INTEGRATED CARE COLLABORATION (ICC) AUTHORIZATION TO USE AND RELEASE CONFIDENTIAL HEALTH INFORMATION

I _____ give my permission to the ICC members, their authorized employees and health care providers to use and release my confidential health information with the other ICC members, their authorized employees and health care providers. I understand that by giving my permission, I will get better quality health care. The current members of the ICC are:

- ◆ Austin/Travis County EMS
- ◆ Austin/Travis County Health & Human Svcs Dept
- ◆ Austin/Travis County Integral Care
- ◆ Austin Women's Hospital
- ◆ Blackstock Family Health Center
- ◆ Central Health
- ◆ Central Texas Medical Center
- ◆ CommuniCare Health Centers
- ◆ CommUnityCare
- ◆ Community Health Centers of So. Central Texas
- ◆ El Buen Samaritano
- ◆ Front Steps Recuperative Care Program
- ◆ Hays County Consolidated ISD Student Health
- ◆ Johns Community Hospital
- ◆ Lone Star Circle of Care
- ◆ National Center for Farmworker Health
- ◆ People's Community Clinic
- ◆ Planned Parenthood of the Texas Capital Region
- ◆ Project Access
- ◆ St. David's HealthCare
- ◆ Samaritan Health Ministries
- ◆ Seton Family of Hospitals
- ◆ Travis County Sheriff's Office Jail Health Services
- ◆ University of Texas Medical Branch
- ◆ University of Texas School of Nursing
- ◆ Volunteer Healthcare Clinic
- ◆ Williamson County and Cities Health District

The ICC may add new members in the future, and I also give permission to release my information to these members as well, but only after they become ICC members.

CONFIDENTIAL HEALTH INFORMATION THAT MAY BE SHARED

I understand that confidential health information that may be shared includes:

- ◆ My diagnosis (the name of my disease or problem)
- ◆ Results of my lab tests, x-rays and other tests
- ◆ Drugs that have been prescribed to me
- ◆ Information about how to contact me, including my name, social security number, address, telephone number, etc.
- ◆ Information about me, including my gender, ethnic group and age

Information in my health records may also be shared about:

- ◆ Mental health (not including psychotherapy notes)
- ◆ Drug or alcohol abuse
- ◆ HIV/AIDS tests or treatments

THE ICARE SYSTEM

I understand that I am visiting a health care provider that is a member of the Integrated Care Collaboration (ICC), and that all ICC members are linked by a computer database that allows them to share confidential information about patients with each other, or with others who join the ICC. I understand that my information can only be placed in the computer database and shared with the ICC members if I sign this Authorization.



REASONS ICC MEMBERS NEED TO SHARE INFORMATION

Sharing your health information helps your provider give better quality care for you and your family.

- ◆ It helps them understand your health history better.
- ◆ It helps them make a more educated diagnosis.
- ◆ It helps them offer better treatment and management of diseases.
- ◆ It prevents you from getting tests or medicines that you may not need, or could harm you.
- ◆ It helps experts study health care for uninsured people so they can make suggestions to improve health care for all.
- ◆ It helps identify whether you are eligible for a pharmacy discount based on your previous medical care.

ALL ICC MEMBERS MAY SEE MY CONFIDENTIAL INFORMATION

I understand that by signing this Authorization, I give my permission for all ICC members, their authorized employees and health care providers to see my information. ICC members may see my information even if they are not my usual health care provider and they would not have my medical records.

PHARMACY DISCOUNT BENEFITS

ICC members use a program that makes some people eligible for discounted medicines based on their previous care. I understand that if I share my information, my doctors may be able to help me qualify for this benefit.

RISK THAT OTHERS MIGHT SEE MY CONFIDENTIAL INFORMATION

I understand that whenever I agree to share my information with someone other than a health care provider who is not required to comply with HIPAA, my information might be shared with someone else for whom the federal rules about privacy may not apply. This is also true for ICC members. The ICC cannot control how my information will be used by the ICC member who receives it under this Authorization.

MY RIGHTS

I MAY REFUSE TO SIGN

I understand that I may refuse to sign this Authorization. If I do refuse, my ability to get health care, payment, enrollment or eligibility for benefits will not be affected.

I MAY CANCEL THIS AUTHORIZATION

I understand that if I sign this, I have a right to change my mind. If I decide I want to cancel this Authorization, I must do it in writing. My cancellation will not affect any actions that have already been taken in reliance on this Authorization, such as confidential information that has already been shared with ICC members. I must give it directly to my provider or deliver or mail my cancellation notice or letter to:

ICC
8627 North Mopac, Suite 140
Austin TX 78759

I understand that if I cancel this Authorization, it may take up to 72 hours (3 days) to lock my information in the database so that other ICC members cannot see it.



I HAVE A RIGHT TO SEE MY RECORDS

I understand that if I sign this Authorization, I have a right to keep a copy of it and to see what information has been shared because of it. If I want to see my records, I must ask my health care provider and not the ICC. I also understand that I may have to pay a fee for copies.

THIS AUTHORIZATION REVOKES AND SUPERCEDES ANY PRIOR AUTHORIZATIONS THAT I HAVE SIGNED. THIS AUTHORIZATION ENDS TWO (2) YEARS FROM THE DAY I SIGN IT, UNLESS I CANCEL IT BEFORE THEN.

Patient Name	Signature of Authorized Person	Date
--------------	--------------------------------	------

Name (if different from Patient)	Relationship to Patient	Date
----------------------------------	-------------------------	------

Witness

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general Authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.