Physicians CareConnection

PHYSICIANS CARECONNECTION
AUTHORIZATION FORM FOR USE AND DISCLOSURE OF INFORMATION

I hereby request and authorize the use and disclosure of any and all information obtained through Physicians CareConnection (including but not limited to protected health information and records of substance abuse (including alcohol/drug abuse), mental health/illness and HIV related information (including AIDS testing) to Central Ohio HUB (and its network of care coordination agencies and healthcare providers, including Healthcare Collaborative of Greater Columbus, Hospital Council of Northwest Ohio, The Ohio Department of Health, and Medicaid Managed Care Plans (CareSource, Molina, United Healthcare Community Plan, Paramount, and Buckeye)), OSU Wexner Medical Center, CompDrug and the Healthy Beginnings at Home (HBAH) program, including Celebrate One, Columbus Metropolitan Housing Authority, Homeless Families Foundation and The SMRT Columbus Rides for Pregnant Mothers program.

The information may be communicated in writing and verbally.

I understand that the disclosure of this protected health information with the entities listed on this form is to help my care team share general information about my family's needs and services I utilize as it pertains to my care plan. I understand the care team will only disclose information that is necessary to provide me with integrative care coordination. This information will be collected and stored on the databases of the entities listed above.

This authorization will expire 2 year(s) from the date of my signature below. I understand that I may shorten, extend or revoke this authorization at any time by notifying:

Physicians CareConnection
Attn: Privacy Officer
1390 Dublin Road
Columbus, Ohio 43215

This authorization and request is fully understood and is made voluntarily on my part. I understand that information disclosed as related to this authorization may be subject to re-disclosure by the recipient of the information. I release Physicians CareConnection, its employees, agents and representatives of any legal liability that may arise from the release of information.

______________________________ ______________________________

Print Patient Name or Person Authorized to Consent* **Signature of Patient or Person Authorized to Consent***

______________________________ ______________________________

Relationship, if not Patient **Date**

***** If this Consent is signed by someone other than the patient, it must be signed in the patient's presence.***