Consent to Services

Better Health Together (BHT)'s Community Care Hub serves people across Ferry, Stevens, Pend Oreille, Spokane, Lincoln, and Adams counties and the Reservations of the Kalispel Tribe of Indians, the Spokane Tribe of Indians, and the Colville Confederated Tribes of the Colville Reservation, connecting them to the unique care that is best for them, whether it be navigating complex health systems, breaking down barriers like language access, or finding vital resources for everyday needs.

By filling out this form, you are allowing us to connect you to a care coordinator at one of our trusted partner organizations who can provide you with the right basic, medical, and cultural support for you.

The Community Care Hub requests your written permission to provide services to you. If you choose to sign this form, the Community Hub can provide services to you and can collect and use your personal and health information ("Information") to help provide those services.

Client Name:__________________________ **Client Date of Birth:**_________________

What Information do we collect and use?

Information from you and other sources	This form covers, without restriction, all Information shared with us by: • you and your family. • Service Providers, such as your care team and any other person involved in your care.
Different types of Information	Information that may be collected and used includes, without restriction: • your name and contact details. • names and contact details of family or caregivers. This will only happen if you give permission and share their contact information. • services you get from Service Providers. • your date of birth, gender, race, ethnicity, tribal affiliation, or tribal enrollment. • details about your health insurance and any needs you may have, such as income, employment, or housing. • healthcare information that may be protected by state, tribal, and federal privacy laws, such as information about your medical providers, health conditions, health needs, and goals.

Signature

By signing below, you agree that:

- You have read this form or that someone has read it to you.
- You understand the terms of this form.
- You have had the chance to ask questions.

By signing, you agree to receive services from the Community Hub as described in this form.

Signature: _________________________________ Date: _____________________

If signed by someone other than the client, please write that person's name and relationship to the

Client.

Name: ____________________________________ Relationship to Client: ______________

Please see next page for authorization to share information.

Authorization to Share Information

Better Health Together provides a way for us and service providers that partner with us ("Service Providers") to share information to coordinate the care we deliver. Service Providers include social service, community, government (tribal, state, and local), physical health, and behavioral health organizations.

Better Health Together and the Service Providers request your written permission to share your Information. Being able to share your Information allows us and Service Providers to better

coordinate your care. This can result in improved access to the care and support you need to be healthy.

If you choose to sign this form, Better Health Together and each Service Provider can share your Information to better:

- learn about your needs.
- coordinate your care.
- provide services to you.

Our goal is to protect your privacy. Please review our the Privacy Policy. It explains what Information gets collected, how your Information is used, shared, and protected, and your rights.

Who will receive my Information if I sign?

Service Providers	Your Information will be shared with Service Providers. We may add to our list of Service Providers at any time. Service Providers: • agree to only access and share Information that is needed to serve you. • are required to protect your Information even if it is no longer protected under applicable privacy laws. We will only share your tribal affiliation or tribal enrollment with Service Providers approved by the Indigenous Nations Committee. **At the end of this form, you can choose to give permission (or not) to allow sharing about sensitive topics, such as healthcare, mental health, substance use, and HIV/AIDS information.**
Our technology providers	Our technology providers will also have access to your Information, but only as needed to run, improve, or repair the technology we use to protect and share your Information.

Why will my Information be shared?

To contact or serve you	We may share your information with a Service Provider to: • contact you. • help Service Providers provide, coordinate, or refer you to services. • learn which services you qualify for. We may share your information with public health to monitor and improve the health of our community.
To improve and help fund our work	Sometimes we may combine your Information with a large number of other people's Information. Combining Information into large groups allows the

	Information to be studied or used while protecting your privacy. After your Information has been combined, you cannot be identified. After your Information is combined with others so your privacy is protected, it could be used to: • evaluate how effective our services are. • improve our services. • help others learn from our work. • help us apply for funding. • report to organizations that fund our work. We may continue to use your Information in these ways after your permission has expired, but not if you cancel your permission.

When will this authorization expire?

Expires after 2 years	Unless you cancel before, this form will expire 2 years after the date you sign it.
Cancel at any time	You can cancel this form at any time. To cancel: • send notice to our Privacy Office by email privacyofficer@betterhealthtogether.org If you cancel, it will only affect future sharing. It will not affect any Information that has already been shared as described in this form.

Permission to share sensitive Information

We need your special permission to share Information about certain types of sensitive Information. This Information may be protected by state, tribal, and federal privacy laws.

You have a choice.

- If you give your permission, this sensitive information will only be shared by us and Service Providers as described in this authorization form.
- If you do not give your permission, you will still have access to services.

I give permission to share health diagnosis and treatment information.

- ❑ Yes
- ❑ No

I give permission to share mental health diagnosis and treatment Information.

- ❑ Yes
- ❑ No

I give permission to share alcohol and drug use disorder diagnosis and treatment Information.

- ❑ Yes
- ❑ No

I give permission to share testing, diagnosis, and treatment for sexually transmitted disease, including but not limited to HIV/AIDS.

- ❑ Yes
- ❑ No

By signing below, you agree that:

- You have read this form or that someone has read it to you.
- You understand the terms of this form.
- You have had the chance to ask questions.

By signing, you authorize Better Health Together and Service Providers to share your Information as described in this form.

Signature: ____________________________________ Date: ____________________

If signed by someone other than the client, please write that person's name and relationship to the Client:

Name: ____________________________________ Relationship to Client: ________________