# Consent to Services

Better Health Together (BHT) has a program called the Community Care Hub. The Community Care Hub helps people find services and support that meet their needs in 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 Confederated Tribes of the Colville Reservation.

We can help you find care and support that works best for you. This may include help with health care, language needs, and resources for everyday needs.

We work with trusted partner organizations. A Care Coordinator may help you find and connect with the right services. 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 Community Care Hub 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 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 information shared with us by:<br>• you and your family.<br>• 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:<br>• your name and contact details.<br>• names and contact details of family or caregivers, if you give permission and share their contact information.<br>• services you get from Service Providers.<br>• your date of birth, gender, race, ethnicity, tribal affiliation, or tribal enrollment.<br>• details about your health insurance and needs you may have, such as income, work, or housing.<br>• health care information, such as your medical providers, health conditions, health needs, and goals. |

## Signature

By signing below, you agree that:

- You have read this form, or someone has read it to you.
- You understand what this form says.
- You had a chance to ask questions.

**By signing, you agree to receive Community Care Hub services as explained in this form.**

Signature: _____ Date: _____

If someone other than the client signs this form, write that person's name and relationship to the client.

Name: _____

Relationship to Client: _____

***Please see the next section for permission to share information.***

# Authorization to Share Information

Better Health Together and its partner service providers may need to share information with each other so they can work together to help you. Service providers may include social service, community, government, tribal, state, local, physical health, and behavioral health organizations.

**Better Health Together and service providers need your written permission to share your information.** Sharing information can help them better understand your needs, coordinate your care, and connect you to services.

Our goal is to protect your privacy. You can review our Privacy Policy. It explains what information is collected, how it is used and shared, how it is protected, and what rights you have.

## Who will receive my information if I sign?

**Service Providers:** Your information may be shared with Service Providers. We may update the list of service providers at any time.
Service providers agree to:

- Use and share only the information needed to serve you.
- Protect your information, even if privacy laws do not fully protect it later.

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 whether to allow sharing about sensitive topics, such as health care, mental health, substance use, and HIV/AIDS information.

**Health Care Authority (HCA):** If you are enrolled in Medicaid insurance, your information may be shared with HCA. HCA manages Medicaid (Apple Health) in Washington state.

**Technology providers:** Our technology providers may access your information only when needed to run, improve, or fix the systems we use to protect and share your information.

## Why will my information be shared?

We may share your information to:

- Contact you.
- Help service providers give you services, coordinate care, or refer you to services.
- Find out which services you may qualify for.
- Help public health programs understand and improve community health.

## To improve and help fund our work

Sometimes we may combine your information with information from many other people. When information is combined this way, your name and identity are not shown.
Combined information may be used to:

- See how well our services are working.
- Improve services.
- Help others learn from our work.
- Apply for funding.
- Report to organizations that fund our work.

We may keep using combined information after your permission expires, but not if you cancel your permission.

## When does this permission end?

**This permission ends after 2 years.** Unless you cancel it earlier, this form expires 2 years after the date you sign it.
**You can cancel at any time.** To cancel, email our Privacy Office at privacyofficer@betterhealthtogether.org.
If you cancel, it only stops future sharing. It does not change information that was already shared before you canceled.

## Permission to share sensitive information

Some information needs special permission before it can be shared. This information may be protected by state, tribal, and federal privacy laws.

**You have a choice.**

- If you say yes, this sensitive information will only be shared as explained in this form.
- If you say no, you can still receive 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 information for sexually transmitted diseases, including HIV/AIDS.**

- ❑ Yes
- ❑ No

## Signature

By signing below, you agree that:

- You have read this form, or someone has read it to you.
- You understand what this form says.
- You had a chance to ask questions.

**By signing, you allow Better Health Together and service providers to share your information as explained in this form.**

Signature: _____ Date: _____

If someone other than the client signs this form, write that person's name and relationship to the client.

Name: _____

Relationship to Client: _____