Vermont Integrated Communities Care Management Learning Collaborative

[COMMUNITY GROUP]
RELEASE OF INFORMATION FOR [Learning Collaborative] PROJECT

Name _____ Date of Birth _____

I WANT TO SEE IF TEAM BASED CARE COULD HELP ME

A Community Group of local care providers is trying out team based care. They want to see if small teams of care providers can get people with [target condition] healthy faster.

I would like the Community Group members to talk to each other about whether team based care is right for me. If the group thinks they can help, they will help me choose a Care Team and keep track of its progress.

I know that I have a right to keep working with the members of the Community Group even if I tell them not to share my information.

MEMBERS OF THE COMMUNITY GROUP

These are all of the providers who are members of the Community Group:

1. [A]
2. [B]
3. [C]
4. [D]
5. [Etc.]

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WHAT THE COMMUNITY GROUP CAN SHARE

The members of the Community Group will have permission to share the following information with each other:

1. My full name
2. Whether they have worked with me
3. My current health problems
4. My recent medical history
5. Updates about my Care Team

HOW THE COMMUNITY GROUP WILL RESPECT MY PRIVACY

The Community Group needs my written permission to talk about anything that is not listed above.

The members of the Community Group will not share any of the information listed above if it would show that I have:

1. Issues related to mental health
2. Problems with drug or alcohol use
3. HIV or AIDS
4. Family court issues
5. A criminal history
6. Other legal issues

WHAT HAPPENS TO MY INFORMATION ONCE IT IS SHARED

1. I know that **my health records could be shared again**. Health information that is shared may no longer by protected under the privacy law known as HIPAA.
2. I know that some of the Community Group members do not have to follow the privacy law known as HIPAA. They will be careful to protect my privacy, but **HIPAA does not protect the records I share with them**.

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HOW TO END THIS RELEASE

If I do not cancel this release, **it will end on its own [in one year]**.

I can also set my own end date here: _____

End Date

I can cancel this release at any time in writing or by contacting:

[Person X]
[Address]
[City], VT [ZIP]
[Phone]

Members of the Community Group will let each other know that this release has been cancelled.

I know that even if I cancel this release, the Community Group members may still have a right to keep and use information that has already been shared.

I know that I have a right to keep working with my providers even if I tell them to stop sharing my information.

SIGNATURE

I know this release will only start once I sign and date this page.

I know that I have a right to keep working with my providers even if I tell them not to share my information.

I know I have a right to get a copy of this form.

_____ _____

Signed by me or my representative Date

_____

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If signed by representative, reason why my representative is allowed to sign for me

_____

Signature of my parent or guardian if I am too young to sign by myself