CONSENT FOR THE DISCLOSURE OF INFORMATION IN CONNECTION WITH THE COMMUNITY INFORMATION EXCHANGE (CIE)

CONSENTING PARTIES

In order for this Consent to be effective, each section of this form must be completed. If the section does not apply, indicate with "N/A".

CLIENT OR REPRESENTATIVE INFORMATION:

Full Client Name: _____ **Birthdate:** _____

Gender: _____ Social Security # (optional): _____

Telephone (optional): _____

Mailing Address (optional): _____

Name of Legal Representative (optional): _____
Basis for Authority to sign on behalf of Client (optional): _____

CIE AND INFORMATION TO BE DISCLOSED

The goal of the Community Information Exchange (CIE) is to help providers give better care to you and your family by enabling better treatment, coordination of care, preventing unnecessary procedures or services, and helping identify eligibility for health or social services and payment programs.

CIE shares information about you to health care, social services and support agencies. The information may include your protected health information (such as self-reported disabling and other health conditions), personal and family history, your name and other identifying information, your present history or enrollment with a social service agency, eligibility for benefits, support services received, and other information contained in your records.

The organizations participating in the CIE are referred to as "Participants". The list of the present Participants in the CIE is available upon request. To see an updated list of the Participants, visit www.CIESanDiego.org, or check with any of the Participants.

PURPOSE OF DISCLOSURE

This Consent is made at the request of the Client, so that participating organizations may provide and use information through the CIE for the purpose of Client's Coordination of Care or Services.

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CONSENT TO DISCLOSE

I, _____**(full client name)**, agree to participate in the CIE. Participants of the CIE may disclose the information detailed above to other Participants of the CIE.

If you choose to limit disclosure of your information, please write the name of the Participant organization(s) you do NOT want to receive your information below. **Otherwise write "N/A":** _____

EXPIRATION DATE OF THIS CONSENT

Unless revoked by you, the individual Client, this Consent shall remain in effect three years from the date of signature.

RIGHT TO REVOKE

You have the right to revoke this Consent as to all or some of the CIE Participants, or to modify this Consent, at any time. You may do so orally or in writing by contacting CIE at www.CIESanDiego.org or contacting any CIE Participant.

CIE Participants will rely on this Consent to release information. If you revoke or modify this Consent, only future releases of information will be bound by your changes.

YOUR RIGHTS

- YOU may refuse to sign this Consent. YOUR refusal will not affect your ability to obtain treatment, payment, services, or eligibility for benefits.
- YOU may inspect or obtain a copy of the information that will be disclosed pursuant to this Consent.
- YOU have a right to receive a copy of this Consent.
- YOU have a right to receive a written summary of the regulations' requirements for disclosure.
- You may revoke this Consent at any time by contacting any Participant or CIEOptin@CIESanDiego.org.

YOUR RIGHTS

Client or Representative's Signature: _____

Consent date: _____ Expiration date (optional): _____

INTERNAL: Consented at 2-1-1 San Diego