Project Access
Collin County
Compassionate Collaborative Care
8680 E. Main Street, Suite 3E
Frisco, TX 75033
Phone: (469) 365-0772
Fax: (888) 977-6892
www.PACollin.org

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Applicant/Client Name (Last, First)

Authorization to Use and Disclose Confidential Health Information

Project Access – Collin County (PACC) is composed of various independent Texas healthcare organizations that provide health care services to individuals living in Collin County regardless of an individual's ability to pay. It may become necessary for PACC partners to use and share confidential health information of participants to better coordinate health care provided to uninsured individuals, to overcome barriers to health care access faced by uninsured individuals, and to implement appropriate disease management systems to improve the health status of uninsured individuals.

This use and disclosure will require an authorization by each uninsured or underinsured individual (or individual's representative) who desire to participate. If you agree to authorize the use and disclosure of your confidential health information among PACC members, as set forth in this form please sign below. By signing below, I authorize employees of PACC, partners of PACC, and health care providers affiliated with PACC partners to use, release and disclose my confidential health care information for the purposes set forth above, to other PACC partners, their employees and health care providers affiliated with PACC.

I understand that "confidential health information" includes diagnoses, diagnostic tests and lab results, and drugs that have be prescribed for me and includes contact information (name, social security number, address, phone number, etc.) and demographic information (gender, race, age, etc.) that is housed in any of the medical records of all the PACC Members.

I understand that information released may include mental health, substance abuse (e.g., drugs, alcohol) and/or HIV/AIDS status, diagnostic and treatment records. IF YOU DO NO WANT THIS INFORMATION DISCLOSED, YOUR OPTION IS NOT TO SIGN THIS AUTHORIZATION. If I sign this Authorization, such information will be received, used and disclosed by PACC Member organizations as authorized by state and federal law.

I understand this is a limited Authorization. I am only authorizing the release of confidential health information that includes diagnoses, diagnostic tests and lab results, drugs that have been prescribed for me; contact information (name, social security number, address, phone number, etc.) and demographic information (gender, race, age, etc.) that is contained in any of the medical records of all PACC Members.

Pursuant to legal agreements with PACC partners, your confidential health information is stored in a centralized health care database operated by PACC. By signing this Authorization, PACC will be allowed to make our confidential health information available through the internet, but only to PACC partners, employees and to health care providers for continuity of care, disease management and health care operations, including quality assessment and improvement and program evaluation.

I fully intend this authorization to cover all PACC partners irrespective of which PACC partner requests that I complete this authorization. Furthermore, I expressly intend that all PACC partners rely on this Authorization, unless and until it is revoked and PACC Members have had a reasonable period of time in which to act on my revocation. I understand that once I sign this authorization it may take approximately two (2) weeks for my medical information to be available to PACC partners and to health care providers affiliated with PACC.

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I understand that I have the right to revoke this Authorization at any time. Revocation must be in writing and sent to:

Project Access - Collin County
8680 E. Main Street
Suite 3E
Frisco, TX. 75033

or hand delivered to:

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8680 E. Main Street
Suite 3E
Frisco, TX. 75033

I understand that if I submit a revocation, there may be a delay between the time the revocation is received by PACC and the time that my information is removed from further disclosure, but that this delay will generally not exceed seventy-two (72) hours.

I understand that any disclosure of information carries with it the potential for disclosure by the recipient and the information may not be protected by the federal privacy regulations.

I understand that this authorization supersedes and revokes all authorizations signed by me at other PACC member organizations for the same purpose, use and disclosure of confidential health information by PACC Members.

I understand that I may review and receive a copy of the confidential health information released pursuant to this Authorization if I request it. I further understand that I may be required to pay a fee for copies of this information.

I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION FORM, AND THAT MY REFUSAL MAY AFFECT MY ENROLLMENT IN PROJECT ACCESS – COLLIN COUNTY AND MY ABILITY TO OBTAIN TREATMENT FROM ANY PACC MEMBER.

I understand this authorization expires two (2) years from the date I sign this Authorization, unless otherwise revoked by me in writing prior to that time.

_____ _____
PACC Applicant/Client Printed Name Date

_____ _____
PACC Applicant/Client Signature Date

I hereby give permission to Project Access – Collin County (PACC) to contact any source to verify statements I have made in my application. I will cooperate fully with PACC personnel to obtain any information necessary to verify statements about my eligibility.

_____ **(Print name of Authorized Representative)** is my representative and I give PACC permission to speak to them in person or on the phone at any time regarding my eligibility or benefits under PACC.

Authorized Representative Information:

PRINT: Last Name, First Name Relationship to Applicant/Client:	Phone Number
Email Address	Signature/Date