



Compassionate Collaborative Care

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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 been 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 NOT 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.

