LINC System Care Coordination Consent and Authorization Form for Disclosure of Personal Information

Mission: LINC (*__L__inking __I__ndividuals to __N__etworks of __C__are*). LINC supports care coordination, ensuring at-risk county residents, including children, find the social, behavioral health and financial services needed to improve overall health and well-being.

Introduction: The **LINC** referral network platform, powered by CrossTx®, supports automated care coordination and closed-loop referral management workflows necessary to support at-risk community members, specifically those facing challenges with social determinants of health.

Description of Services: LINC is a HIPAA secured web-based referral network platform. The **LINC** referral network is a place for service providers to coordinate health and social care.

Purpose: To allow access to your information for care coordination services including referrals to organizations across the **LINC** referral network.

Information Shared: This consent covers all information shared by you or by anyone that has the right to share information on your behalf. With your consent your information may be shared electronically, verbally or written. This includes health information that may involve sensitive information such as health and medical history records, hospitalizations, residential and outpatient treatment records, testing results/labs, and demographic information (name, date of birth, address, phone number, email). You can always limit the information you provide on the **LINC** referral network by requesting to have it removed.

Data Privacy/Confidentiality: LINC is a HIPAA secured web-based referral network platform. By participating in the **LINC** referral network, you agree and consent to provide your personal information to receive health and social care coordination services. Your personal information will be shared among the **LINC** referral network service providers.

Revocation: If you no longer want your information shared on the LINC referral network, you can email LINC@flaglercares.org or ask any the **LINC** referral network service providers. Any information already shared with or in reliance upon consent cannot be taken back.

Person Receiving Care Coordination:

Name:

DOB:

Address:

Phone:

Email:

Consent for Services: Read and fill the checkbox by each item below to illustrate your consent.

- [ ] **I authorize the LINC referral network service partners to communicate with me in writing, electronically, or by telephone, as may be necessary for the purpose of my care coordination and management.**
- [ ] **I understand that my records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless otherwise required or permitted by law.**
- [ ] **I may, without consequence, withdraw my participation from LINC at any time after signing this document.**
- [ ] **I may request and receive a copy of this signed consent form at any time.**

Consent Effective Period: This consent is good for one-year from date signed or until date of revocation.

By signing below, I acknowledge that I have read and understood the above information and agree to care coordination and referrals.

____
Print Name of Person Receiving Care Coordination

Is this person over 18 and/or able to sign this consent form on their own?

____
Print Name of Legal Representative, if applicable

____ ____________________________________
Signature of Person, if over 18/able to sign **Date Signed**

____ ____________________________________
Signature of Legal Representative, if applicable **Date Signed**

Relationship of Legal Representative

Parent of minor

Legal Guardian

Other Personal Representative

- Explain: ____