LEGACY COMMUNITY HEALTH

DISCLOSURE AND CONSENT TO SHARING OF PROTECTED HEALTH INFORMATION

______________________________ Printed Name of Patient ______________ Date of Birth

Participation in the Health Choice Network

Legacy Community Health Services ("Legacy") receives its electronic health records system (EHRS) through an arrangement with the Health Choice Network ("HCN"). HCN, as a business associate of Legacy, supplies EHRS technology to Legacy as well as to other HCN participants. Under this arrangement, your personal health information may be shared with other HCN participants or a health information exchange only when necessary for medical treatment or for health care operations purposes. Legacy monitors the sharing of your personal health information with HCN participants to verify that, if needed, only the minimally necessary information is shared. You have the right to change your mind and withdraw consent to share of your personal health information, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of HCN participants to which your information has been disclosed.

Participation in the Greater Houston HealthConnect

Legacy participates in Healthconnect, a non-profit organization that provides a secure electronic network for Healthconnect participants. A list of current Healthconnect participants is available at www.ghhconnect.org. Legacy's participation with others in Healthconnect, such as labs, pharmacies, radiology centers, doctors' offices, hospitals, and health insurers, permits Legacy to access, and utilize in providing care to you, any available electronic health information related to you. All Healthconnect participants must protect your privacy in accordance with state and federal laws. Your treatment and eligibility for benefits will not be affected. By my signature below, I agree that Healthconnect and its current and future participants, including Legacy, may use and disclose my protected health information electronically for the limited purposes of treatment, payment and health care operations. I understand that Healthconnect may connect to other health information exchanges in Texas and across the country that also must protect my protected health information in accordance with state and federal laws, and I authorize Healthconnect to share my information with those exchanges for the same limited purposes of treatment, payment and health care operations. This authorization remains in effect unless and until I revoke it. I understand that I can revoke this authorization at any time by giving written notice to any healthcare provider who participates in Healthconnect and my revocation will be effective within three (3) days. I also understand that revoking this authorization does not affect information previously shared when my authorization was in effect.

(initial) _____ **In order to receive the benefit of coordinated care between my healthcare providers, I choose to participate for myself, or on behalf of my minor child, in the Greater Houston HealthConnect Health Information Exchange (recommended).**

(initial) _____ I request that my health information, or that of my minor child, be excluded from Greater Houston Healthconnect. I understand this means that other health care providers will not be able to obtain my health information, or that of my minor child, through Greater Houston Healthconnect except to the extent action has already been taken to release information, and they may still obtain it through other methods.

Participation in the Care Everywhere Health Information Exchange

Legacy participates in the Care Everywhere Health Information Exchange. Care Everywhere allows doctors and nurses from different organizations to electronically exchange patient health information. It is a tool within our electronic medical record that is used to securely share patient health information with other healthcare providers. Anyone who receives care at participating Care Everywhere organizations may benefit from Care Everywhere. Whether you are traveling and need emergency medical attention, or perhaps you visit other healthcare providers in the community, Care Everywhere allows these providers to access more information about your health status so that they can better meet your medical needs.

Information that will not be shared through Care Everywhere includes:

- Behavioral health treatment
- Substance abuse program services
- Sexual abuse/Forensic records

Only health care professionals involved in your care during your health care visit can view your information. Healthcare professionals may only access your information to coordinate your care and treatment.

This authorization remains in effect unless and until you revoke it. You can revoke this authorization at any time by giving written notice to Legacy Community Health, Compliance Department, P.O. Box 66308, Houston, TX 77266 or by email to Compliance@legacycommunityhealth.org. Your revocation will be effective within (3) days. You understand that revoking this authorization does not impact PHI previously shared when your authorization was in effect. State and federal laws still allow access to most of your health information, or that of your minor child, without your written consent, as long as the request is made by other health care providers who are involved in your care, or that of your minor child. This information would be shared via telephone, mail or facsimile.

You understand that when your PHI, or that of your minor child, is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations.

(initial) _____ In order to receive the benefit of coordinated care between my healthcare providers, I choose to participate for myself, or on behalf of my minor child, in the Care Everywhere Health Information Exchange (recommended)

(initial) _____ I request that my health information, or that of my minor child, be excluded from Care Everywhere. I understand this means that other health care providers will not be able to obtain my health information, or that of my minor child, through Care Everywhere except to the extent action has already been taken to release information, and they may still obtain it through other methods.

CONSENT TO TREATMENT, TESTING, AND PROCEDURES

I consent to all tests, treatments and procedures ordered by Legacy providers including, without limitation, testing for communicable or blood-borne diseases such as sexually transmitted diseases, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and Hepatitis. As part of my testing and treatment, I may receive disease- specific prevention, education, and risk-reduction services. I understand that Legacy is required by state law to report information to the City of Houston Department of Health & Human Services for persons who test positive for certain diseases (known as “reportable diseases”) including, but not limited to, tuberculosis, HIV/AIDS, and syphilis. If I test positive for a reportable disease, I understand that I will be contacted by a state-authorized Disease Intervention Specialist to promote successful treatment and notification of any sex partners, if applicable, who may be at risk for the disease.

I also understand that if a Legacy health care worker is accidentally exposed to my blood or body fluids, (for example by a needlestick), Legacy can draw and/or use blood drawn from me for testing purposes.

FINANCIAL RESPONSIBILITY

I understand that if I qualify for services through a grant funded program such as Ryan White or the Department of State Health Services Family Planning (Title X) these resources are payers of last resort. As payers of last resort, grant-funded programs may not continue my eligibility if I currently or in the future have Medicare, Medicaid and/or third-party insurance coverage. Therefore, I agree to immediately report any changes in my financial status and/or insurance coverage to the Eligibility Specialist. If I fail to appropriately report changes in my financial status and/or insurance coverage, and if those changes result in my ineligibility for services under a grant funded program, I understand that I am fully responsible for the cost of services delivered by Legacy.

INSURANCE ASSIGNMENT

By signing below, if I am eligible for Medicaid, Medicare and/or third-party insurance coverage while a client of Legacy, I authorize Legacy to furnish to Medicaid, Medicare and/or third-party insurance coverage all of the necessary information, including my HIV status, to process my claim. I also hereby assign to Legacy all payments received from Medicaid, Medicare and/or a third-party insurer for services and treatments provided to me by Legacy. I understand that I may be responsible for paying any required co-payments prior to being seen by a health care practitioner. I also understand that I am responsible for the cost of services and treatments delivered to me that are not covered by my insurance.

RESEARCH PARTICIPATION

Legacy participates in research studies, which can involve proven or experimental treatments. By signing below, I authorize Legacy staff to review my information to determine if I qualify to participate in current or future studies. If I qualify, I will be notified and provided with the opportunity to accept or decline research participation. My signature below does not mean I agree to be in a research study.

E-PRESCRIBING

E-Prescriptions, E-RX or Electronic Prescriptions, are computer-generated prescriptions created by your provider and sent directly to your pharmacy. Legacy participates in E-prescribing because we care about your health and well-being and E-prescribing has multiple benefits. By consenting, Legacy can also access a history of my current and past prescriptions. This critical information assists Legacy in confirming the safety of my prescriptions and minimizing dangerous interactions with my other medications.

COMMUNICATIONS

I understand that my email address and other contact information that I have provided will be used by Legacy for various purposes including, but not limited to, appointment reminders, prescription medication refill reminders, and registration for Legacy's patient portal. Legacy's secure patient portal allows patients to communicate with their health care providers and access some information in their medical records such as medication lists, certain laboratory results, and immunization records, however, these features may change from time to time. I understand that my email address will be used by Legacy to create a secure portal account for me, but that I will be required to establish my login information in order to access the portal.

IMPORTANT INFORMATION YOU NEED TO KNOW ABOUT TELEHEALTH/TELEMEDICINE AT LEGACY

Limitations of Telemedicine/Telehealth

As a Legacy patient receiving services via telemedicine/telehealth, your provider is required to provide notice (an explanation) regarding telemedicine/telehealth services, including the risks and benefits of being treated via telemedicine/telehealth, how to receive follow-up care or assistance in the event of an adverse reaction to the treatment or in the event of an inability to communicate as a result of a technological or equipment failure.

Necessity of In-Person Evaluation

As a Legacy patient receiving services via telemedicine/telehealth, your provider is required to inform you before the conclusion of the encounter, if he or she is unable to provide all pertinent clinical information that a health care provider exercising ordinary skill and care would deem reasonably necessary for the practice of medicine or health services at an acceptable level of safety and quality in the context of that particular medical encounter. If that occurs, your provider is required to advise you to obtain additional medical evaluation reasonably able to meet your needs.

Rights and Responsibilities, Recording Telemedicine Appointments

I understand that by agreeing to participate in Legacy's telemedicine/telehealth services, I will not audio and/or audio/video record Legacy workforce members without their express permission obtained in advance of any recording. A violation of this recording limitation may result in Legacy requesting that I destroy the recording, including any postings of the materials that have been shared and may also result in Legacy discontinuing telemedicine/telehealth services to me.

COMPLAINTS TO THE BOARD

As a Legacy patient receiving services, if you wish to file a grievance or complaint with the Texas Board of Medicine or Legacy's Risk Manager, please contact Legacy at compliance@legacycommunityhealth.org, (832) 548 5018, or via mail at: PO Box 66308, Houston, TX 77266. You will not be penalized for filing a complaint.

Terms of Consent

I understand my consent is necessary for Legacy to offer services to me and that some items may not apply to my current situation. I also understand that, in order to provide comprehensive care during this and future visits, and to evaluate my eligibility for programs, my signature below indicating my agreement to this document in its entirety, is required. By signing this form, I acknowledge and agree to the terms, information and obligations contained in this document. I am giving this consent of my own free will. I have had the opportunity to read and ask any questions about the information in this packet, specifically including, but not limited to, the financial obligations provisions and assignment of benefit provisions.

I acknowledge that I either have no questions or that my questions have been answered to my satisfaction in a language I understand. I sign this document freely and agree to abide by its terms. I understand that this document remains in effect until I revoke my consent, at any time, in writing. I also understand that revoking this authorization does not affect any actions previously taken based on this consent.

By signing this form, I attest that all the statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give the Legacy eligibility staff any information necessary to confirm statements about my eligibility. I understand that giving false information could result in eligibility disqualification and a possible repayment obligation. I also agree to inform the eligibility staff should my income or number of people in my family change.

My signature below acknowledges I have been provided with a Patient Information Package, which includes a:

- Notice of Privacy Practices, explaining how my health information will be handled in various situations;
- Statement of Client Rights and Responsibilities, which I agree to abide by;
- Feedback/Concern/Complaint/Grievance Policy for filing complaints;
- E-Prescribing Information Sheet; and
- Legacy Patient Agreement.

By my signature below, and/or my initials above, I acknowledge that I have been given ample opportunity to ask questions, all questions were answered to my satisfaction, and I consent to the above on my behalf, or on the behalf of my minor child, and that I have been provided with a Patient Information Package, which includes a:

- Notice of Privacy Practices, explaining how my health information will be handled in various situations;
- Statement of Client Rights and Responsibilities, which I agree to abide by;
- Feedback/Concern/Complaint/Grievance Policy for filing complaints;
- E-Prescribing Information Sheet; and
- Legacy Patient Agreement.

Signature of Client or Parent /Guardian or Power of Attorney	Date
Signature of Person Who Helped Complete this Form	Date
Signature of Witness	Date