AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FROM CCH TO HOUSING ASSISTANCE AGENCIES

CCH PERSONNEL: When a Cook County Health (CCH) patient or CountyCare enrollee has agreed to have their information shared with Housing Assistance Agencies: 1. Complete this Form with the Patient/Enrollee (or Representative if individual is under 18) 2. Request the Patient/Enrollee or Representative to sign the Form	**Referral Date**

Last Name	**First Name**	**Middle Initial**

Birth Date	**Primary Language**
Phone Number	**Address**
Preferred Day/Time for Contact	

1. My information that may be used or shared (disclosed) – check all that apply:

- ☐ Name
- ☐ Birthdate (Age)
- ☐ Address
- ☐ Diagnosis
- ☐ Treatment Information
- ☐ Other – please describe:

SPECIFIC CONSENT SECTION Please note if the below is not completed, this information will NOT be released.

Check any or all of the boxes below to authorize this information to be used or shared (disclosed) in connection with the services offered by Housing Assistance Agencies as described below. Information about:

- ☐ A Mental Illness or Developmental Disability
- ☐ HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of these tests were positive or negative)
- ☐ Communicable Diseases
- ☐ Sexually Transmitted Infections
- ☐ Substance (i.e. alcohol or drug) Abuse
- ☐ Abuse of an Adult with a Disability
- ☐ Sexual Assault
- ☐ Child Abuse and Neglect
- ☐ Genetic Testing
- ☐ Artificial Insemination
- ☐ Psychotherapy Notes (which are not part of the official medical record)

- All Chicago, Housing First, the City of Chicago, and the County of Cook partner with housing assistance agencies to connect eligible CCH patients and CountyCare health plan members with permanent supportive housing opportunities.
- By signing this form, you will allow CCH to share your demographics (the information above) and health information with the housing assistance agencies and their partners to assist in identifying permanent supportive housing opportunities.
- This Authorization will expire twelve (12) months from Today's Date.

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Last Name	First Name	Middle Name

Initial each box below	
	I acknowledge that CCH cannot and will not condition treatment, payment, enrollment, or eligibility on whether I sign this authorization.
	I understand that once my health information is shared (disclosed), it will be disclosed to one or more third parties and used by them to identify housing resources. My information may be re-disclosed by the Housing Assistance Agencies who may not be required to comply with this Authorization or privacy laws.
	I understand that I have the right to inspect or copy any information used/disclosed under this authorization.
	I understand that I may revoke this authorization at any time by notifying CCH in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by CCH before receiving my revocation and will not prevent third parties from disclosing my information if it has already been provided to them. **Any revocation under this paragraph should be mailed to: Corporate Compliance, 1950 W. Polk Street, Suite 9217, Chicago, IL 60612**.
	I have read and understand the terms of this Authorization and I have had a chance to ask questions about the use and disclosure of my health information. I authorize CCH to share (disclose) my health information as described in this Authorization.

I authorize CCH to disclose the above information to the Housing Assistance Agencies.

Signature of Patient/Enrollee	**Date**
FOR AUTHORIZED REPRESENTATIVES OF THE PATIENT/Enrollee	
Name of Authorized Representative	**Relationship to Patient/Enrollee**
I hereby certify that I have the legal authority under applicable law to grant this authorization and make this request on behalf of the patient identified above.	
Signature of Personal Representative	**Date**

Place Patient Label Here