Camden Coalition
of Healthcare Providers

Sample Patient Consent Form

A patient consent form allows us to gather information to share with providers for the purpose of care management and coordination. The form lists the systems with whom we connect. We invite you to use the consent form from which to model your own form. You may want to include the obtaining of claims data to your form in order to provide pre and post intervention cost data for your patients. You should speak with your legal team to determine what policies and procedures are in place to interact with patients, and develop a consent form ensuring you gain access to the patients' medical records and claims data.

800 Cooper Street 7th Floor • Camden, NJ • 08102
www.camdenhealth.org • @camdenhealth • 856.365.9510

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize:

- ☐ Cooper Health System
- ☐ Virtua Health System
- ☐ Our Lady of Lourdes Health System
- ☐ CAMcare
- ☐ Project H.O.P.E.
- ☐ My insurance plan: _____
- ☐ My provider(s): _____
- ☐ Other: _____

To use and disclose a copy of the specific health information described below regarding:

_____ (Name of individual) _____ (Date of Birth)

_____ (Address of Individual)

_____ (City, State, Zip Code)

Consisting of:

- ✓ History and physical examinations
- ✓ Laboratory reports
- ✓ Discharge summary
- ✓ Bioelectric output (i.e., EKG, EEG)
- ✓ Other, specify_____
- ✓ Consultation reports
- ✓ Operative reports
- ✓ X-ray/Diagnostic images
- ✓ Tissue and/or blood specimens

To: Camden Coalition of Healthcare Providers, Attn: Care Management Team
800 Cooper St, 7th floor
Camden, NJ 08102
Phone (856) 365-9510; Fax (856) 365-9520

For the purpose of: ***Care management and care coordination***

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my **INITIALS** in the applicable space next to the type of information.

- ×_____ HIV/AIDS information
- ×_____ Mental health information
- ×_____ Genetic testing information
- ×_____ Drug/alcohol diagnosis, treatment, or referral information

This authorization is voluntary, and you may refuse to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services from your usual providers; however, your refusal to sign this authorization will affect your ability to participate in this care coordination project.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

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I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I understand that my health information may be shared with health care providers, social workers, nurse case managers, health lawyers, community agencies, and other professionals who have been, are currently, or will be involved in my care in order to better coordinate my care.

I have read this authorization and I understand it.

Unless revoked, this authorization does not expire.

By:× _____ Date: _____
(Signature of individual or Legally Authorized Representative)

Description of relationship to individual: _____