CIFC Health

Authorization for Consent

CIFC Use of Health Information Exchange (HIE):

We participate in one or more secure electronic Health Information Exchanges ("HIEs") that allow authorized health care providers, health plans, and other organizations to share your health information for permitted purposes such as treatment, payment, and health care operations. Sharing through an HIE helps coordinate your care and improve quality and efficiency.

Your information may be shared electronically with other HIE participants, including hospitals, physicians, pharmacies, laboratories, and health plans, and may include information created by us or received from others.

Unless you choose to opt out below, your health information may be shared as described above. You may opt out at any time, except where disclosure is required by law or needed for your care team to obtain information related to your treatment.

☐ **Opt out of CIFC HIE sharing**

Check this box only if you do NOT want your health information shared for the purposes listed above.

Health Information Exchange (Connie):

We participate in Connie, Connecticut's state-designated Health Information Exchange (HIE). Sharing through Connie helps coordinate your care and reduce delays or duplicate testing.

Unless you select one or more boxes below, this information may be shared through Connie as permitted by law. You may opt out at any time at www.conniect.org or by calling **(866) 987-5514**.

Do NOT share the following information through Connie:

☐ HIV/AIDS

☐ Behavioral Health

☐ Substance Use Disorder

Financial Agreement & Assignment of Benefits:

I give CIFC Health permission to send bills for services to Medicare, Medicaid, or any other insurance company for me and my children under age 18 who are listed on the demographic form. I also give CIFC Health permission to share my or my child's health information with the insurance company, which includes mental health care, substance use, or HIV information, if needed for payment.

I understand that I am responsible for paying all charges for services for me and my children under age 18 who are listed on the demographic form. This includes deductibles, co-pays, and co-insurance; services my insurance does not cover; and any amount left after my insurance pays.

I understand that I must notify CIFC Health immediately of any changes in my insurance.

I allow my insurance company to send payment directly to CIFC Health or its providers for services provided to me or my children under age 18 who are listed on the demographic form. If my insurance denies the claim because I am not eligible, my coverage has ended, or for any other reason, I agree to pay the full amount owed as soon as possible.

I understand that CIFC Health offers a sliding fee scale discount program for charges based on my income, and I agree to notify CIFC Health immediately of any changes in my income. I understand that I can talk to the FIA Department to learn more about the sliding fee scale discount program.

Authorization to Treat:

I give permission to the staff of CIFC Health to provide routine medical, dental, and behavioral health care for me and my children under age 18 who are listed on the demographic form. Care may include tests (including an HIV test), medicines, shots, vaccines, or other treatments that are based on standard medical guidelines but may have some risks. My provider will explain the risks to me in advance. I understand that I have the right to say no to any test, treatment, service, or medicine, as allowed by law. I understand that students and health care trainees may help with my care under the supervision of CIFC Health clinical staff.

CIFC Health

Uses and Disclosures of Information and Notice of Privacy Practices Acknowledgment:

I authorize CIFC Health to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to maintain my health information in an electronic health record system and to use secure technology to improve healthcare delivery; (3) to enable CIFC Health to obtain payment for the services it provides to me; and (4) to permit CIFC Health to carry out ordinary health care and business operations such as quality assurance, service planning and general administration.

I am aware that this authorization to use and disclose information may include information regarding: (1) HIV or AIDS; (2) substance use disorder treatment; (3) psychiatric or behavioral health; (4) sexually transmitted diseases; and (5) reproductive health. I am aware and agree that CIFC Health may share information with my other medical providers for medical treatment or with a third party for financial payment through electronic means.

I authorize CIFC Health to request and use my prescription medication history from other health care providers and/or third-party pharmacy benefit payers for treatment purposes. This consent form will remain in effect until the day I revoke consent. To revoke consent at any time, I will speak to the registration manager of the department.

A description of how CIFC Health may use or disclose health information about me, my rights related to my health information and how to file a complaint if I feel that my rights have been violated is in CIFC Health's Notice of Privacy Practices (NPP). My signature/electronic signature below acknowledges that I have been offered or received a copy of CIFC Health's NPP and that I can access a copy any time at https://www.cifc.org/home-page/page/privacy-statement or at any clinic location.

Patient Name: _____ **Date:** _____ / _____ / _____

Signature of Patient or Parent/Legal Guardian: _____

Printed Name of Parent/Legal Guardian (if signed above): _____