BEACON
COMMUNITY CONNECTIONS

CLIENT CONSENT FORM

Consent to Use and Disclose Your Protected Health Information for Resource Allocation and Support Services

Statement of Confidentiality: Beacon Community Connections will not share your Personal Health Information (or PHI) with any outside agencies without your verbal permission, except as required by law or in a situation deemed potentially life threatening.

Notice of Privacy Practices: Beacon Community Connections understands that health information about you is personal. We comply with the Louisiana State and Federal Laws concerning personal health information.

Resource Allocation and Support Services: As we provide services to you, we may be collecting and retaining information about you in your record. This information is referred to as Protected Health Information or PHI. By signing this consent form, you are allowing us to use and disclose this PHI to assist you with contacting and locating support services to better improve your health. If you do not sign this consent form, allowing us to use and disclose your PHI to other agencies, we will not be able to refer you to certain programs that may be helpful to you. This is necessary for us to provide you with quality care. For example, we may need to be able to use and disclose this information to other agencies that may have eligibility requirements for their programs. We will only share the necessary information needed by other agencies to serve you.

Contact with you: With this consent, Beacon Community Connections may call and leave messages on your phone, send text messages or emails, have contact in person, or other alternative contacts given by the organization that referred you, in reference to anything that might assist you, such as appointment reminders, resources, and services that can assist with improving my health, follow-up/check-in calls and emails, and any calls thereafter.

Request to restrict disclosure: If you are concerned about some of your health information being used or disclosed, as outlined in this consent form, you have a right to request, in writing, a restriction or limitation on the health information we use or disclose about you for treatment, resource allocation, referrals, or health care operations. We will comply with your request unless the information is necessary to treat you, is needed to provide you with emergency treatment, or if complying with the request is against the law. After signing this request., you have the right to revoke it (by submitting the request in writing) and we will comply with the request, with the understanding that we cannot take back any uses or disclosures that may have already been made with your permission, and that we are required to retain our records of the care that we have provided you.

By signing below, I acknowledge that I have read, and I understand this consent form from Beacon Community Connections. I have signed or have provided verbal consent to create referrals and contact other agencies on my behalf. Verbal consent will be documented below.

Print Name: _____

Signature: _____ Date: _____

Witness Name: _____ Date: _____

Signature: _____