PROJECT ACCESS

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Authorization to Share/Collect Health Information for Project Access

1) I, _____, allow my doctor(s) and or any other health care providers to give medical information relating to my use or need of the Project Access program and their services. This information can include spoken or written facts about my health and payment and or benefits. It can include copies of records from any or all of my health care providers.

Project Access will only use and give out this information to see if I qualify for the Project Access program and to administer their program. People that work for and with Project Access may also see my information, but they may use it only to help me get assistance with medical care, pharmaceuticals, durable medical equipment and data collection. I understand that they will make every effort to keep my information private and confidential, but if it is accidentally given out, federal privacy laws are waived.

This authorization will last until I am no longer participating in the Project Access program. If I change my mind before that time, I will notify in writing the Project Access Director, my health care providers, and physician (s) that I do not want them to share any additional information with Project Access. However, this will not change any actions that were taken before I advised them of my change of mind. I know that I have a right to see or request, for a nominal fee, a copy of the information that is contained in my Project Access working file. I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. If I refuse to sign this form, I know that it means that I may not be able to participate in the Project Access Program.

Patient Sign Here: _____ Date: _____

Patient Name (printed): _____

If the patient cannot sign, patient's person representative must sign below:

Patient Name: _____By: _____
(Signature of person signing for patients)

Relationship: _____

In addition, I authorize **Basic Health of Washington** and **Health For All** to exchange my personal information with Project Access, and Project Access to provide Basic Health of Washington and Health For All my personal information. This information can include spoken or written facts about my health, payments, financial information and or benefits. It can include copies of records that I have provided to either entity. This permission will continue as long as I am enrolled in Project Access unless I notify Project Access, Basic Health of Washington

Patient Sign Here: _____ Date: _____

Patient Name (printed): _____

If the patient cannot sign, patient's person representative must sign below:

Patient Name: _____By: _____
(Signature of person signing for patients)

Relationship: _____