HEALTH PROMOTION COUNCIL
a PHMC affiliate

building connections to health

Centre Square East
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Christina Miller, MSS
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President-Elect

Jerry C. Johnson, MD
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Health Promotion Council's Consent to Participate in Medical Home Community Team Program and Authorization to Release Patient Information

A. Medical Home Community Team Purpose & Services

The Pennsylvania Chapter of the American Academy of Pediatric Medical Home Initiative and the Philadelphia Department of Public Health Division of Maternal, Child and Family Health have partnered in support of the Medical Home Community Team (MHCT) under the umbrella of Health Promotion Councils' (HPC) initiatives. The purpose of the MHCT is to provide direct services to referred families, and advocate for their needs.

Our philosophy is based on recognizing the strengths and resources of each one of our clients by seeing each client as an equal partner in developing a service plan to meet their needs and to build a stronger connection with your medical home. With your authorization, MHCT will provide in home services and referral resources to support your child(ren) and family, including:

- Assistance navigating medical systems
- Referrals for local community resources and social services
- Care coordination, including integration and working partnerships with your child's primary care provider
- Transition to adult medical care support
- Individualized health education

B. Patient acknowledgement and consent

In order to initiate and provide ongoing supports to you, the client, it will be necessary for Health Promotion Council's Medical Home Community Team to access your child's protected health information (PHI), and establish as well as maintain regular communications with your current primary care provider per below. By signing this consent and authorization form, you are agreeing to participate in the MHCT program, agreeing that your child's PHI may be released to the MHCT team, and permitting us to maintain ongoing communication with your child's PCP. **Disclaimer: this program does not require that your provider send the MHCT your child's medical record.**

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I, _____, hereby

(Caregiver name)

Authorize_____

(Medical Home Name)

On behalf of _____, Child Date of birth _____

(Childs name) (MM/DD/YYYY)

to release my confidential information to Health Promotion Council, as requested.

This permission is reciprocal, i.e., I am giving my permission for both parties identified above to communicate back and forth with one another, including sharing of medical, social or psychological results, participation/progress/attendance in social service or other programs, and all other relevant information.

I understand that all information obtained by Health Promotion Council will remain confidential and will only be available to Health Promotion Council staff in order for me to receive services. I am further aware that unless rescinded, this authorization to release information will expire one year from the date below.

I understand that I have the right to revoke my consent at any time by written request to the extent that the person who is to make the disclosure has already acted in reliance on it.

I certify that this form has been fully explained to me and I understand that authorization will expire one year from my dated signature.

_____ _____

Client (Caregiver) Signature **Date**

_____ _____

Additional Caregiver Signature **Date**

I certify that I reviewed this document with the above client(s):

Initials: _____
Date: _____