COMMUNITY INVOLVEMENT PROGRAMS
Helping people live their greatest lives

Release of Information, Payment Authorization, Explanation of Data Practices Act and Tennessan Warning, and Acknowledgment of Receipt of Notice of Privacy Practices

Name (print): _____

Date of Birth: _____ / _____ / _____ Program: _____

1. Release of Information

I authorize Community Involvement Programs to use personal, financial, service, health, and medical information about me to the extent permitted by law and to disclose such information to the following:

- To a health care or social services provider, a county/state/federal agency, members of my interdisciplinary team, and other professional persons or agencies involved in my care;
- To a health plan, insurer, third party payor, third party administrator or other organization providing me with benefits, for the purposes of claims payment and benefit determinations, audits or investigations, or quality of care studies or reviews;
- To a person or organization in connection with Community Involvement Programs' operations. These operations may include but are not limited to interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, and other related activities;
- To a health information exchange where my information may be shared with and accessed by other health care providers and health care related entities for purposes of treatment, payment, and the health care operations of the participating organizations; and
- To the following individuals involved in my care (e.g., name spouse, other family member, friend, personal representative):

  _____
  _____
  _____
  _____
  _____
  _____
  _____

I understand that my case manager, staff providing services to me in connection with my coordinated service and support plan or other treatment plan, and applicable licensors may have access to my information in accordance with applicable law.

I understand that I may access records maintained by Community Involvement Programs about me to the extent permitted by state and federal law, including to the extent permitted by the federal HIPAA statute.

I understand that this consent is valid until I revoke it, which I may do at any time by giving written notice to:

Community Involvement Programs
Attn: Executive Administrator
1600 Broadway St. NE.
Minneapolis, MN 55413

2. Payment Authorization

Payment Responsibility. I agree to pay for all services furnished to me by Community Involvement Programs that are not paid in full by my insurance, government program benefits or other third-party payors, upon receipt of a statement, except as prohibited by Community Involvement Programs' contract with my health plan or applicable law.

Payment Authorization. I authorize Community Involvement Programs to directly bill my health plan or third-party payor for services rendered to me by or on behalf of Community Involvement Programs but acknowledge that Community Involvement Programs is not obligated to submit claims to third-party payors on my behalf unless required by law or by its

contract with a particular third party payor. I also authorize any third-party payor through which I may have benefits to make payment directly to Community Involvement Programs for such services. I understand I am financially responsible to Community Involvement Programs for charges not covered by my insurance.

3. Explanation of the Minnesota Data Practices Act & Tennessan Warning

The information Community Involvement Programs requests is needed to determine your eligibility for public funds, to distinguish you from others, to enable us to collect federal, state, or county funds for services we provide to you, and to satisfy federal, state, or local statistical requirements. Refusal to provide the information we request may interfere with our ability to serve you.

The information Community Involvement Programs collects will be used to help staff assist you in completion of your program at Community Involvement Programs. This information may be shared with local, state and federal governments (such as auditors, Hennepin County Bureau of Social Services, the Department of Human Services, the Social Security Administration, and the Veterans Administration); with other Community Involvement Programs staff; and with members of the Interdisciplinary team, including representatives of social service agencies, parents or guardians, and other professional persons and agencies directly concerned with providing service to you inclusive of employers. It may also be shared with medical personnel in emergency situations. Information about you will be retained as long as federal, state, and local laws require, and until federal, state or local audits are complete.

You may review all the public and private data about you. You may challenge information about you, and have any incorrect information changed. If you request, data about you may not be shared with other agencies without your explanatory statement attached. Data about you that is confidential because it is so classified by statute will not be available to you.

I understand the provisions of the Data Practices Act as explained, an authorize CIP to use information about me as described above.

4. Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Community Involvement Programs' Notice of Privacy Practices.

_____ _____
Signature of individual *Date*

_____ _____
Signature of legal representative (if applicable) *Date*

Legal representative name (printed): _____

Relationship to individual: _____