Special Consent for Release of Sensitive Information
Barth Clinic

Client Name:		Other Names:
DOB:	Address:	Phone Number:

Purposes for Release

The purpose of this Consent is to request and authorize Barth Clinic to use the Collective Platform to electronically transmit and disclose the sensitive information described below to past, present, or future members of my Care Team through the Collective Network for purposes of enabling members of my Care Team to provide Treatment to me. (See reverse side for answers to some Frequently Asked Questions).

Consent to Release Sensitive Information

I hereby request and authorize Barth Clinic to disclose my sensitive information and records as described below through the Collective Platform operated by Collective Medical Technologies, Inc. to the members of my Care Team identified below who are connected to or participate in the Collective Network. This consent and request applies to information and records concerning diagnosis and treatment of me as a minor, if applicable.

Amount and Kind of Sensitive Information to be Disclosed [Check **ONE** of the following boxes]

☐ Option #1: Full Care Documentation. Any of the following types of sensitive information or records which are available in Barth Clinic's electronic record (e.g., clinical notes, discharge summaries, care plans, lab results, medications, etc.) to my Care Team for purposes of providing me Treatment, including:

- Substance use (alcohol or drug) diagnosis and treatment information and any information related to my treatment at, or any records from, any substance use disorder program (including medications, treatment plans, clinical assessments or tests, symptoms, diagnoses, progress notes, etc.)
- HIV/AIDS or sexually transmitted disease (STD) diagnosis or treatment information and records
- Mental health, behavioral health, and developmental disability diagnosis and treatment information and records, whether on an inpatient or outpatient, or voluntary or involuntary basis
- Adult day program service information

☐ Option #2: Limited Care Team & Care Encounter Information. Only my sensitive information limited to identifying: (1) the type of providers who are members of my Care Team, such as providers that specialize in substance use (alcohol or drug) treatment or referral services, mental health (inpatient or outpatient, HIV or sexually transmitted diseases, developmental disability services, adult day programs and Social Services Providers; **AND** (2) the dates, locations, and types of encounters with such providers (e.g., associated diagnosis, complaint, service or location codes or information, etc.).

To Whom My Sensitive Information May be Disclosed

The sensitive information and records described above may be disclosed to all of the past, present, and future members of my Care Team (including Health Care Providers, Behavioral Health Providers, and Social Service Providers), which may access my sensitive information indicated above to enable them to provide Treatment to me as part of my overall Care Plan.

I understand that:

- I am authorizing Barth Clinic to disclose the sensitive information I have designated above, for the purposes and to the parties described in this Consent.
- My decision to sign this Consent is voluntary, and I understand that I may refuse to sign this Consent. My refusal to sign will not affect my ability to obtain Treatment or payment or my eligibility for benefits.
- As required under federal law (42 CFR Part 2, § 2.13(d)), upon my request Barth Clinic will provide me with a list of entities to which my sensitive information has been disclosed under this Consent.
- I understand that I have a right to receive a copy of this Consent.
- I understand that I may revoke (i.e., take back) my Consent in writing at any time. My revocation will take effect upon receipt by Barth Clinic except to the extent that others have already acted in reliance upon this Consent.
- My Consent will expire either upon my death, or if and when I decide to revoke it.

Client Signature:		Date:
Legal Representative (if any)	Signature:	Name:
Reason Client is unable to sign (if applicable):		
Relationship to Client: ☐ Parent ☐ Guardian/Conservator ☐ Health Care Power of Attorney ☐ Other Legally Authorized Representative under applicable state law (specify: _____ _____)		

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Definitions and Frequently Asked Questions
Barth Clinic

What is the Collective Network?

Barth Clinic participates in the network operated by Collective Medical Technologies, Inc. ("**Collective**") which connects Health Care Providers, Behavioral Health Providers, Social Service Providers, and managed care and other health insurance organizations ("**Collective Network**"). The Collective Network enables health care providers and organizations to connect and collaborate by sharing electronic health information for their shared patients through Collective Medical's software applications so they can better coordinate their efforts to provide safe, convenient, integrated care to you.

What is the Collective Platform?

The "**Collective Platform**" is a technology platform underlying a suite of software applications which enable health care providers to share historical summaries about your health care visits,, recommendations for how to best meet your needs when you visit a health care provider, contact information of your health care providers, and other information that can help these providers deliver care to you or perform care coordination activities on your behalf. The Collective Platform can also alert your Care Team about certain health care events, like when you have an emergency department visit, or when you have been discharged from the hospital after an inpatient stay.

Who is my Care Team?

Your "**Care Team**" includes your past, current, or future treating providers who have attested to Collective that they have a treating-provider relationship with you. Your Care Team may include a variety of health care professionals or facilities, such as "**Health Care Providers**" which are authorized under state law to provide health care or medical services (e.g., doctors, nurses, pharmacists, hospitals, health centers, etc.), "**Behavioral Health Providers**" authorized under state law to provide mental health or substance use disorder or referral services (e.g., psychiatrists, psychologists, counselors, other mental health professionals or substance use counselors, certain social workers, etc.), or "**Social Service Providers**" authorized under state law to provide diagnosis, evaluation, treatment, or consultation services (e.g., social workers, nurses, or other individuals with such professional licensure or credentials as required under state law).

What kind of activities does the term "Treatment" include?

The term "**Treatment**" includes activities related to the provision or coordination of health care and related services by one or more members of your Care Team, including referral or consultation for any condition for which you may receive care, including medical, mental health, or substance use disorder. Your Care Team may work with you to develop a plan of care (or "**Care Plan**") that includes a summary of your diagnosis, treatment goals, and treatment activities. Treatment activities can include sharing your information as may be necessary for your Care Team to provide a referral, conduct an evaluation, provide updates about your health care encounters or visits or new services, programs or benefits for which you are eligible, or sharing changes or updates to your Care Plan.

Why doesn't this Special Consent Form cover my general medical information?

HIPAA and applicable state privacy laws permit Collective to enable health care organizations which have a relationship with you and which participate in the Collective Network to use the Collective Platform to share your general medical information for treatment, payment, or health care operations purposes (as those terms are defined by HIPAA) without your specific authorization or consent. Collective and the health care organizations that have a relationship with you cannot share certain categories of your "sensitive information" that are protected under state or federal law, unless you sign a specific consent form which meets applicable legal requirements. The purpose of this Special Consent Form is to enable you to authorize members of your Care Team to have access to this sensitive information to better enable members of your Care Team to provide Treatment to you.

Am I required to participate in the Collective Network or can I opt-out?

Your participation is voluntary, and you may refuse to allow your information to be shared through the Collective Platform. You may choose not to sign this Special Consent Form, in which case your Care Team will not be able to share your sensitive information through the Collective Platform. You may also choose to "opt out" of allowing Collective to share your general medical information between health care organizations you work with. If you are interested in learning more about opting-out, ask Barth Clinic for more information about opting-out of the Collective Network.

Will signing this Special Consent Form affect other consents or authorizations I have signed?

You may have signed other consent or authorization forms, and your signing this Special Consent Form does not limit or revoke those other consents or authorizations.

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