CHCC ASTHO Hypertension Program
Authorization for Disclosure of Protected Confidential Information

Family Care Clinic (FCC) has teamed up with the Division of Public Health to connect you with the ASTHO HIC Program at their practice, dieticians who live and work in your community and are knowledgeable about social service supports and medial resources that may benefit you and your family. This project coordinator will be contacting you to set up your self-management plan that focuses on:

1. Hypertension Measurement
2. Mediation Assistance
3. Developing a Relationship with your Physician
4. Nutrition Plan from CHCC registered dietician
5. Blood pressure cuff for
6. Pair of walking shoes

As the person signing this authorization, I understand that I am giving permission for the Family Care Clinic and Division of Public Health to discuss and share my confidential information.

I agree:

☐ To Family Care Clinic sharing my confidential information (my name, address, phone number, etc.) with DPHS and for program evaluation purposes.

☐ To a Project Coordinator contacting me with information and resources for improving my health. This may include one-on-one meetings depending on your situation and plan created with the Care Coordinator

I understand:

☐ The Project coordinator will help me explore areas where I may need help and refer me to community resources and programs, particularly specific to hypertension

☐ I will receive appropriate care from FFC whether I sign this agreement or not

☐ The FCC staff agrees that the confidential information will only be disclosed for the Purpose of facilitating my healthcare and evaluation the effectiveness of this project and will not be discussed with anyone else. FFC and DPHS will not disclose, publish, or otherwise reveal any of the confidential information to any other person whatsoever with the written consent of the client

Consent:

I agree to participate in the CHCC ASTHO Hypertension program

Print Name: _____ Contact Info: _____

Signature of Participant: _____Signature of Parent/Guardian: _____

Signature of Witness/Interpreter: _____ Date: _____