Care Coordination Program: Referral Form

This form is to be filled out by a patient's Medical Provider or Case Manager on behalf of a patient seeking/currently receiving hepatitis C treatment and who is interested in enrolling in HEP's Care Coordination Program. Please fill this packet out with the patient and fax any relevant release of information forms to HEP at (206) 299-0855. Fill in as much information as possible. All services are offered free of charge. Health insurance is not required to access HEP's services. One of HEP's Care Coordinators will reach out to the patient as soon as possible. If you have any questions, please call or email Russell, Lead Care Coordinator, at (206) 430-4554 or russells@hep.org. Thank you for the referral!

Patient Name:			**Date of Birth**:	
Contact Information	Phone Number:		OK to leave detailed message?	☐ Yes ☐ No
	Email Address:		OK to contact you via email?	☐ Yes ☐ No
	Mailing Address:		Ok to send mail to this address?	☐ Yes ☐ No

Does the patient have a primary care provider? ☐ Yes ☐ No **If yes - Provider Name**:_____

Clinic: _____ **Provider Phone:** _____ **Provider Email:** _____

Does the patient have health insurance? ☐ Yes ☐ No ☐ Don't Know

If yes, what kind of health insurance do you have? ***(check below)***

☐ AppleHealth/Medicaid ☐ Medicare ☐ Dual Medicaid & Medicare ☐ Private ☐ Tricare/Tribal

☐ Other: _____ ☐ Don't Know

Date of patient's hepatitis C antibody test (finger poke): _____

Date of patient's hepatitis C confirmatory test (blood draw): _____

Any other known relevant health information? (i.e., FibroScan results, HBV or HIV co-infection, diabetes, kidney disease, other serious health conditions) _____

Provider/Case Manager able to fax patient's medical records/lab results to HEP? ☐ Yes ☐ No

What does the patient need help with or have questions about related to their hepatitis C care?

HEP HEPATITIS EDUCATION PROJECT

HEPATITIS EDUCATION PROJECT
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

TO: Hepatitis Education Project
1621 S Jackson St. #201
Seattle, WA 98144

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I. Information About the Disclosure of My Protected Health Information

As the person who is the subject of protected health information I, _____, request and authorize the Hepatitis Education Project to disclose my protected health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information. Unless revoked earlier, this authorization will remain valid for six years from the last date on which your Protected Health Information is disclosed hereunder.

Protected Health Information to be disclosed (including date(s) of relevant treatment): _____

_____

_____

Purpose of disclosure of my Protected Health Information: _____

_____

_____

Persons/Organizations or Categories of Persons/Organizations authorized to receive my Protected Health Information:

_____

_____

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- This authorization is voluntary, I am not required to sign this form, and I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for any benefits or enrollment, treatment, or payment for or coverage of services.
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party, but any obligations related to or liability for violations of such assurances will remain the sole responsibility of the above-named persons/organizations providing such assurances.
- A copy, facsimile, or electronically transmitted version of this signed Authorization may be treated as valid for all purposes related to this form.

III. Signature of Participant or Participant's Representative

_____ _____

Signature of Patient or Participant's representative **Date**
(Form MUST be completed before signing.)

Printed name of Participant's personal representative: _____

Relationship to the Participant, including authority for status as representative: _____