PATIENT CARE FORM
ROCKINGHAM COUNTY HEALTH CARE ALLIANCE NETWORK

The purpose of this form:
This health care organization is a member of the Health Care Alliance Network (RCHA). The RCHA is a group of organizations that work together to improve the health of Rockingham County residents. RCHA providers are using electronic health records and electronic networks that will allow them to collect information about patients and their treatments and share this information confidentially and safely with other providers who are also treating these patients. RCHA providers and staff involved in your health care are authorized to access your health records in order to provide and coordinate your health care. In addition, RCHA, participating providers, their employees, agents and associate executives may have access to information necessary to enable them to determine their eligibility for health care, assistance in the prescription program, and other public or community services; to keep these businesses running and improve patient services, and to offer other services related to the community.

Your provider will ask you to sign this authorization form that has your information included in the RCHA networks. Your decision about participating in the RCHA network is completely VOLUNTARY. If you sign the form it will be valid for two years. By signing this document, you are giving permission to participants and suppliers of RCHA, its employees, agents and associated companies to share personal information and information related to your health related to eligibility, health status and medical treatment. Your information will not be shared unless you sign the authorization form.

You can cancel your authorization at any time by completing the cancellation form that can be purchased with any participating provider. The cancellation does not affect information that has already been shared and is effective only after RCHA receives a cancellation form completed properly and that it deactivates the information in the data system.

How to share information helps your health provider offer you more medical care:
• Providers can better understand their medical history
• Prevents the duplication of studies or medicines that you do not need.
• May help you qualify for discounts for prescription drugs and other services.

Examples of information that can be shared:

- Patient's name, address, phone number, gender, date of birth, race / ethnicity, social security number, job information, and emergency contacts.
- Information about your income status, health insurance status, eligibility for public assistance programs, and other financial information.
- Records of doctors, hospitals, clinics and centers where you have received treatment, now or previously.
- Records of medical treatment, hospitalization, surgery, diagnostic procedures, (laboratory tests, x-rays, CT scans, etc.), prescription drugs, medical devices, and related services.
- Diagnosis of diseases and medical conditions, including but not limited to: mental illness (excluding psychotherapy notes), substance abuse, HIV / AIDS, pregnancy, and termination of pregnancy.

Information Security and Privacy

Federal and state laws require that medical providers prescribe the privacy and security of patient information. The RCHA will use and maintain appropriate protection mechanisms to protect the information on the network. In their case, patients will receive the HIPPA Notice of Private Practices from their provider, which provides additional information about the respective policies of confidentiality of providers.

Patient Authorization

- I understand that by signing this form, I give permission for all current and future RCHA participants, their employees, agents and associated businesses involved in my care, to view my personal health and financial records in the RCHA network. Providers can see this information even if they are not my usual providers who do not have my previous medical records.
- A participating provider can obtain information about health services that I have received previously and that I have received with other participating RCHA providers.
- I understand that my health information may include my medical history or information including communicable diseases, mental illness, alcohol and medical substance abuse.
- I understand that this authorization will be valid for two years, at least until I cancel it.
- I understand that I have the right to cancel this authorization at any time when completing a cancellation form, which I can obtain from any participating provider. Cancellation does not affect the information already shared.
- I understand that if I sign as a patient representative, I am certifying that I have authority under North Carolina law to make health care decisions for the patient.
- I understand that no participating provider can access information about my data unless I go to that participating provider for treatment, and unless the information from my previous health care treatment has already been entered into the RCHA network.
- I acknowledge that I have received a copy of this authorization.
- I understand that my decision about whether to participate in the RCHA network is completely VOLUNTARY and that no participating provider can condition my treatment on whether I sign this form.

My signature below indicates my authorization for my health and financial information to be entered into the RCHA network and shared with current and future participating providers and their business partners.

Signature of patient or representative: ____ Date: ________

Patient's Name: ____ Date of Birth: ________

Witness: ____ Date: ________

Relationship with the patient (if applicable): ____

Facility / provider: ____