

**PERMISSION TO USE AND DISCLOSE PROTECTED INFORMATION**

**CONTACT INFORMATION**

Client Name: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**What is the Community Network?**

The Alamo Area Community Network (“AACN”) provides an alliance of many different community organizations (collectively, the “Community”) in and around San Antonio, Texas working to provide community care and limited health and educational support services (“Services”) to individuals. The Community works together as a “Community Care Team” to help provide for your basic and specialized needs. You can see a complete listing of all partners in the Community by using the following link: <https://ouraacn.org/explore-the-alamo-area-community-network>.

**What is the Purpose of the Community Network?**

The Purpose of the AACN is to create a “virtual village” for your Community Care Team to work together on a common platform to provide you with Services. **With your permission, the Community can work together and make note of your basic and specialized needs.** This is why we are asking for your permission to share information about you within the Community (together, the “Purpose”). Your information is shared electronically among your Community Care Team on SYNC powered by the AACN, a cloud-based data-sharing platform.

**What types of information could be shared on the Community Network and what are my rights?**

Generally, any information you share with your Community Care Team may be shared amongst the Community to achieve the Purpose described above. For an in-depth description of our collection and treatment of your information along with your rights to such information, please use the following link: <https://ouraacn.org/platform-terms-of-use/privacy-policy/>.

In addition, certain information may be protected by laws, including the Health Insurance Portability and Accountability Act (“HIPAA”). If your information is protected by HIPAA, please use the following link for more information: <https://ouraacn.org/platform-terms-of-use/hipaa-policy/>.

As a reminder, the use of the Community is only intended for those currently residing in Texas, and the information is only intended to be collected from those currently residing in Texas.

**Must I sign the Authorization to receive services?**

**You do not have to give your permission** to seek Services from the Community, but without your permission, **Community partners cannot send referrals for Services on your behalf.** Your treatment, ability to receive Services, payment, enrollment, or eligibility for benefits do not depend on your signing this form.

**AUTHORIZATION**

I hereby authorize and grant permission to the AACN and my Community Care Team to use and disclose my information to partners of the Community for the Purpose. **By signing below, I acknowledge that I have read and I understand this Authorization form, including the [general privacy policy](#) , [the HIPAA policy](#)  referenced above, and my rights with respect to my information. I also acknowledge that I have been given a copy of this Authorization form.**

Signed: \_\_\_\_\_

Printed name: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Self \_\_\_\_\_ Parent / Guardian of Minor Child (Under 18) \_\_\_\_\_ Guardian/Conservator of Adult Client

[Please see page 2 to add authorization for minors in your care.]

This form allows you to provide authorization for minors you are legally responsible for.

By signing below, I acknowledge that I have read and understand the previous page of this Authorization form. I also acknowledge that any contact information left blank below will be assumed to be the same as the contact information provided on the previous page.

**Contact Information for 2nd Client**

Client Name: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Signed: \_\_\_\_\_

Printed name: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Self \_\_\_\_\_ Parent / Guardian of Minor Child (Under 18) \_\_\_\_\_ Guardian/Conservator of Adult Client

**Contact Information for 3rd Client**

Client Name: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Signed: \_\_\_\_\_

Printed name: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Self \_\_\_\_\_ Parent / Guardian of Minor Child (Under 18) \_\_\_\_\_ Guardian/Conservator of Adult Client

**Contact Information for 4th Client**

Client Name: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Signed: \_\_\_\_\_

Printed name: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Self \_\_\_\_\_ Parent / Guardian of Minor Child (Under 18) \_\_\_\_\_ Guardian/Conservator of Adult Client