AUTHORIZATION FOR THE USE AND DISCLOSURE OF INFORMATION
COMMUNITY INFORMATION EXCHANGE

Full Name:*		**Today's Date: ***
Gender:	**Birthdate:***	**Full or last 4 SS#/ 4 Digit Pin: ***
Phone Number: *		**Email: ***
Agency Name:*		**Agency Staff: ***

All items marked with * are mandatory.

You are authorizing People for Irvine Community Health dba 2-1-1 Orange County, dba Community Information Exchange (CIE) and its Partner Agencies to use, store, and share your personal, financial and health information with each other in order to assess your needs, coordinate your care and provide services to you. Partner Agencies participating in the CIE are listed at https://gethelpoc.org/content/Community-Partners.html.

This Authorization covers, without restriction, all information disclosed and re-disclosed to CIE by you, your family, Partner Agencies including your care team, or any other person involved in your care while this Authorization is in effect. CIE and its Partner Agencies may share your personal, financial and health information. You agree to notify CIE if your information changes or is incorrect. Information disclosed pursuant to this Authorization may be re-disclosed and no longer be protected under applicable privacy laws. However, your information will still be protected under our Participation Agreement with our Partner Agencies. Your refusal to sign this Authorization will not adversely affect your ability to receive health care or services from Partner Agencies.

Notice of Privacy Practices is posted at www.gethelpoc.org. This explains how CIE uses and protects information, how to get a copy of this Authorization and your record. You can revoke this authorization at any time by sending notice to CIE at revoke@211oc.org, allowing a minimum of **five business** days to process. Revocation will not affect any information previously disclosed in reliance on this Authorization. Unless revoked earlier, this Authorization will expire in **Ten (10) Years, or on the following Date: _____.**

☐ I authorize for CIE to use and disclose information relating to, Drug/Alcohol/Substance Abuse, Mental Health, and HIV/AIDS.

If you agree, sign your name below:

Client's Signature: *