Client Consent for Advocacy Services and Authorization to Disclose Protected Health Information (HIPAA)

Hearts & Minds Patient Advocacy INC

Mission: We provide support and advocacy for patients and their families as they encounter health obstacles.

Vision: Each patient and/or family member feels adequately supported and heard during their health endeavors improving their healthcare experience.

I. Client/Patient Information

Field	Details
Patient Name:	_____
Date of Birth:	_____
Phone Number:	_____
Email Address:	_____
Date Advocacy Services Begin:	_____

II. Consent for Advocacy Services (Authorization to Act)

I, the undersigned client or authorized representative, hereby voluntarily authorize **Hearts & Minds Patient Advocacy INC** to act as my designated Patient Advocate.

This authorization permits the assigned advocate, case coordinator, and necessary supervisory staff to perform the following actions **on my behalf**:

- **Communicate and Consult:** Speak directly with any identified healthcare providers, insurance companies, government agencies (e.g., Medicaid), social workers, case managers, and other individuals or facilities involved in my care.
- **Attend Appointments:** Accompany me to all medical, hospital, and specialist appointments.
- **Care Coordination:** Assist with day-to-day tasks, regular wellness checks, and coordinate logistical details of my care plan and treatment options.
- **Resource Attainment:** Seek, apply for, and help me attain necessary medical, financial, and community resources, including post-partum resources for expecting mothers.
- **Financial and Legal Support:** Assist with matters related to **financial management and will planning**, particularly for elderly and critically ill patients.

This authorization for the Advocate to act is valid until the authorization for PHI disclosure (Section III) expires or is revoked.

III. Authorization to Disclose Protected Health Information (PHI)

This section is a **HIPAA-compliant Authorization for the Disclosure of Protected Health Information (PHI)**.

A. Parties Authorized to Disclose PHI (Who May Release My Information)

This authorization applies to **all** healthcare providers, hospitals, clinics, community health centers, laboratories, pharmacies, and any other entity or person that has created or received my health information, including those listed below (if any):

1. _____
2. _____
3. _____

B. Recipient Authorized to Receive PHI (To Whom the Information May Be Released)

The designated recipient is: **Hearts & Minds Patient Advocacy INC**, including its assigned Case Coordinators and Patient Advocates.

C. Description of the PHI to Be Disclosed (What Information May Be Released)

I authorize the release of ALL my protected health information that is necessary for the Advocate to fulfill the duties outlined in Section II, including, but not limited to:

Medical Records, Billing Records, Discharge Summaries, Lab Results, and Treatment Plans.
I also authorize the release of the following potentially sensitive health information (please initial next to each category to grant authorization):

| Category | Initial to Authorize |

| Mental Health Records | _____ |

| HIV/AIDS-related Information | _____ |

| Alcohol/Substance Abuse Records | _____ |

D. Purpose of the Disclosure (Why the Information is Being Released)

The purpose of this disclosure is for **Patient Advocacy, Care Coordination, Resource Attainment, and securing the necessary support** to improve my overall healthcare experience.

E. Expiration and Right to Revoke

1. **Expiration:** This Authorization will expire on the date the Client-Advocate relationship is formally terminated, **OR** on this specific date: _____.
2. **Right to Revoke:** I understand that I may revoke this Authorization at any time by sending a written notice to **Hearts & Minds Patient Advocacy INC**, except to the extent that action has already been taken in reliance on this Authorization.
3. **Refusal to Sign:** I understand that I may refuse to sign this Authorization and that my refusal will not affect my ability to obtain treatment, payment, or enrollment benefits.

F. Understanding of Re-disclosure

I understand that once my PHI is disclosed, federal privacy law (HIPAA) may not protect it. The recipient may re-disclose it. **Hearts & Minds Patient Advocacy INC** will, however, treat all my information as confidential and will only use and disclose it for the purposes of advocacy as outlined in this form.

IV. Signatures

Field	Signature	Date
Client/Patient Signature:	_____ _____	_____ ____
Advocate/Witness Signature:	_____ _____	_____ ____
If signed by a Representative	_____ _____	_____ ____

(e.g., family, guardian):		
Relationship to Patient:	_____ _____	