GILEAD
COMMUNITY SERVICES, INC. • Serving Middlesex County
Improving Lives, Building Futures

CONSENT TO TREATMENT AND TO USE/DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND OPERATIONS

Subject to the statements printed on page two, I, _____(Print Name), the undersigned client, agree to participate in Gilead Community Services, Inc.'s programs and give my consent for Gilead to provide me evaluation, treatment, and other services that may be mutually agreed upon. I also hereby authorize Gilead Community Services, Inc. to use my medical information, including, if applicable, protected drug and/or alcohol abuse, confidential HIV-related, and psychiatric information ("Protected Health Information" or "PHI") for treatment, payment, and health care operations purposes.

In addition, I authorize Gilead Community Services, Inc. to disclose my Protected Health Information (which may include, but is not limited to, my name, address, date of birth, dates of service, and medical information, including psychiatric, drug/alcohol abuse, and confidential HIV-related information) to the following:

- Authorized Gilead personnel both within and outside of my program/s for the purposes of enhancing my treatment and/or ensuring the quality of my care.
- My health insurance provider/s (i.e. Medicaid, Medicare, Blue Cross & Blue Shield, etc.) or other payor/s I notify Gilead of, as necessary, for the purposes of processing health insurance claims & payment for provided services.
- Pharmacies, laboratories, or other third parties who perform functions essential to my healthcare, to best coordinate my care.
- The State of Connecticut's Department of Mental Health & Addiction Services (DMHAS) and its designees for the purposes of payment, treatment coordination, and quality assurance (*Only if I am receiving Gilead services that are funded by DMHAS*).
- The State of Connecticut's Department of Children & Families (DCF) and its designees for the purposes of payment, treatment coordination, and quality assurance (*Only if I am receiving Gilead services that are funded by DCF*).
- Other and for what purpose: _____

Gilead Community Services, Inc.'s Notice of Privacy Practices further explains how Gilead may use and disclose my Protected Health Information. I understand that I have the right to review such notice before signing this consent. I also understand that Gilead Community Services, Inc. reserves the right to change its privacy practices described in its Notice, and that if I wish to receive notification of any changes to the notice, I may contact Gilead's Client Rights & Privacy Officer. Updated Notices are also posted at each Gilead program or on Gilead's website at www.GileadCS.org.

I understand that I have the right to request that Gilead Community Services, Inc. restrict how protected health information about me is used or disclosed for treatment, payment, or health care operations, and that Gilead Community Services, Inc. is not required to agree to this restriction. If Gilead Community Services, Inc. does agree to a restriction I request, Gilead Community Services, Inc. will be bound by our agreement.

This consent will be valid for a period of one year from the date below or one year after discharge, whichever is later. I understand that I have the right to revoke this consent by notifying Gilead's Client Rights & Privacy Officer in writing, except where Gilead Community Services, Inc. has already taken action in reliance on this consent. However, I also understand that Gilead Community Services, Inc. may condition treatment on my granting of this consent and that if I revoke my consent, I may be discharged.

I have had the opportunity to have all my questions answered regarding Gilead Community Services, Inc.'s Privacy Practices.

Client Signature: _____ Date: _____

Conservator/Guardian Signature: _____ Date: _____
(If Applicable)

Any information released by Gilead Community Services, Inc. to authorized persons is subject to the following notices:

Psychiatric Information:

In the event that information released constitutes confidential psychiatric information protected under Connecticut law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law.

Drug and Alcohol Abuse Information:

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

HIV-Related Information:

In the event that information released constitutes confidential HIV-related information protected under Connecticut law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.