## LINC Consent Form

**Introduction:** The LINC system is a shared platform and Database that allows Authorized Users to enter and track client information, make referrals to other Agencies in the LINC Network and collaborate on health & social care.

**Purpose:** To create and store a personal record and allow access to your personal and health information for health and social care coordination services including referrals to agencies across the **LINC** system.

**Data Privacy and Confidentiality: LINC** is a secure platform and Database that meets all national standards for Health Insurance Portability and Accountability Act (HIPAA) privacy rule. By participating in the **LINC** system, you agree and consent to share your personal information to receive health and social care coordination services.

**Information Shared:** This consent covers all information shared by you or by anyone that has the right to share information on your behalf. With your consent, your information may be shared electronically, verbally or written. This includes health information that may involve sensitive information such as health and medical history records, hospitalizations, residential and outpatient treatment records, testing results/labs, and demographic information (name, date of birth, address, phone number, email). You can always limit the information provided to a **LINC** system agency by requesting in writing through a release of information exactly what personal and health information you would like limited or not shared at all.

**Revocation:** If you no longer want your information shared in the **LINC** system, you can email LINC@flaglercares.org or ask any of the **LINC** system agencies to revoke your consent. Any information already shared with or in reliance upon consent cannot be taken back.

**Person Receiving Health and Social Care Coordination:**

**Name:**
**DOB:**
**Address:**
**Phone:**
**Email:**

**Consent for Services:** Read and initial by each item below

- ☐ **I authorize the LINC referral network service partners to communicate with me in writing, electronically, or by telephone, as may be necessary for the purpose of my care coordination and management.**
- ☐ **I understand that my records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless otherwise required or permitted by law.**
- ☐ **I may, without consequence, withdraw my participation from LINC at any time after signing this document.**
- ☐ **I may request and receive a copy of this signed consent form at any time.**

**Consent Effective Period:** This consent is good for one-year from date signed or until date of revocation.

**By signing below, I acknowledge that I have read and understood the above information and agree to health and social care coordination and referrals.**

_____ _____

Client Signature Date