Breathe Easy at Home Program
Authorization to Use and Disclose Health Information

We are asking you to allow us to forward your and your child's information to the Breathe Easy at Home Program.

- The Breathe Easy at Home Program is a collaboration amongst several city agencies, including, the Inspectional Services Department's Housing Inspection Division, Boston Medical Center, Boston Public Health Commission, Boston Urban Asthma Coalition, Bowdoin Street Health Center and the Asthma Regional Council of New England. This program is designed to improve access and communication among medical providers, public health agencies and housing agencies with the goal of improving housing conditions for children who suffer from asthma and whose conditions may be exacerbated due to their poor housing environment.

What information will be forwarded to the Breathe Easy at Home Program?

- We will give to Inspectional Services your:

____Name ____Address ____Phone number
____Number of people in your home who suffer from asthma and the severity of their condition
____Other information with respect to your housing conditions

What does it mean to forward my or my child's information to the Breathe Easy at Home Program?

- Through the Breathe Easy Program, you and your family will be given priority with respect to housing inspections.

- We may discuss with the Breathe Easy at Home Program the nature of your family's health, how poor housing may be attributing to asthma/respiratory incidents in your home, whether and how the Breathe Easy Program is assisting your family and how the Breathe Easy Program may further assist your family.

- If you sign this form, you are agreeing to let us forward your information to the Inspectional Services Department and to disclose your information to other organizations associated with the Breathe Easy at Home Program.

Taking part in the Breathe Easy at Home Program is voluntary.

- Your participation is completely up to you. You do not have to agree to let us identify you or refer you to Inspectional Services. Your decision (either yes or no) will not affect your being able to get health care at **(INSERT HEALTH CENTER INFO HERE)** or payment for your health care. It will not affect your enrollment in any health plan or benefits you can get.

You can stop participating in the Breathe Easy Program at any time.

- You do not have to give us a reason.

- You can stop your participation at any time by writing to:

  (INSERT HEALTH CENTER PRIVACY OFFICER HERE)

  Please state in writing that you wish to withdraw your authorization to disclose your health information to the Breathe Easy at Home Program. Please date and sign your letter. Please also let your pediatrician or health care provider know that you no longer wish to participate in the program.

- If you take back your authorization, it will not affect any actions we took before we received your letter.

- The U.S. Privacy rule does not protect information that is disclosed with the permission of this form.

You have the right to get a copy of this form.

This authorization will expire 5 years from the date that you sign below unless withdraw it sooner.

If you sign this form, you are agreeing to let (INSERT HEALTH CENTER INFO HERE) use or give out your health information as described above.

PATIENT NAME (Print)	**PATIENT DATE OF BIRTH**
DATE	**SIGNATURE (Patient or Authorized Representative)**
AUTHORIZED REPRESENTATIVE NAME	**DESCRIBE AUTHORITY (e.g. Parent, Guardian)**

NOTE: Form must be signed by or for all family members and others present