BRAZCO RESOURCE COLLABORATIVE
STRENGTHENING COMMUNITIES THROUGH PARTNERSHIPS

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What is the BrazCo Resource Network?

The BrazCo Resource Network (**"Network"**) is a coalition of community organizations in Brazoria and surrounding counties in Texas working together to provide community, health, and supportive services (**"Services"**) to individuals in the community. Organizations participating in the Network include food banks, transportation service providers, respite care providers, health care providers, philanthropic organizations and schools, and entities that assist with housing, utility and other basic needs.

Permission to share your Protected Information?

The purpose of the Network is to refer you to organizations to assist you with your health care and basic needs. With your permission, community organizations can work together to collaborate and record the things you may need, such as food, nutritional care, clothing, housing assistance, job training, respite care, service coordination, and access to care. Staff and volunteers at the various organizations will want to reach out to you to coordinate services for you. This is why we are asking for your permission to share your Protected Information within the Network (**"Purpose"**). Protected Information is shared electronically among your Team on CHN MSS™, a cloud-based data sharing platform hosted by CHN MSS.

What types of Protected Information could be shared by on the Network?

Certain federal and state laws exist to protect you and your information. This **"Protected Information"** includes records in the following Categories (**"Categories"**):

- **Community Care Coordination and Referral Records,** including past, present, and future information needed to determine benefits eligibility, obtain authorizations, make referrals, enroll, and abide with government reporting requirements (such as: funding authorizations; services received; disability status; employment information; resources and income; limited medical information related to referral and hospitalizations; social media profile information; case management information including service plans, social history, discharge summaries and client contact information; and all applications, investigation reports, and case records pertaining to medical assistance or other government benefits described under Texas law or federal law).
- **Health Information,** including past, present, and future medical and mental health diagnoses, treatment, referral, prescription, and billing records that are necessary for provision of Basic Needs.
- **HIV/AIDS and Other Sexually Transmitted Diseases,** including records that identify test results.
- **Substance Use Disorder,** including past, present, or future substance use disorder diagnoses, treatment, referral, prescription, and billing records that are necessary for provision of Basic Needs and Specialized Needs.
- **Education Records,** including past, present, and future school health, disciplinary, and attendance records; transcripts; cumulative records; and directory information.

These laws require your permission to use and disclose your Protected Information to improve the Services offered in support of your Basic Needs. Therefore, the Network and CHN MSS must have your express permission to share your Protected Information within the Network. **By completing and signing this form, you are giving your permission.** You can of course continue to seek services from organizations that participate in the Network, even if you do not give permission to share your Protected Information, but you will not be able to use the Network to receive those services. **Your treatment, receipt of Services, payment, enrollment, or eligibility for benefits are not conditioned in any way on your signing this form.**

Who could use or disclose my Protected Information if I've granted permission?

Community organizations on the Network hosted by CHN MSS that are actively providing Services to or in support of your Basic Needs.

If I grant permission, for how long will my Authorization be valid?

Your Authorization will be valid for ten (10) years, unless you exercise your right to revoke it sooner, as described below, or turn eighteen (18).

What are my rights once I have granted permission?

- You have a right to know who has seen your Protected Information. The Network will give you a list of all persons or entities with which your Protected Information has been shared pursuant to this Authorization. You can request this list by sending an email to noreply@brazconetwork.org. By signing below, you acknowledge this right.
- You have the right to revoke this Authorization at any time. To do so, email a "Revocation Notice" to noreply@brazconetwork.org. For the Revocation Notice to be effective, you must include a combination of data sufficient to identify you such as your name, date of birth, address, telephone number, and email.
- Submitting a Revocation Notice will change how your care team can provide you with Services. Specifically:
    - Your care team will no longer be able to disclose your Protected Information in the future, EXCEPT in a medical emergency or as otherwise allowed for treatment, payment, or healthcare operations of your treating providers or payers.

    - Your care team will still be able to share your Protected Information if it was created or shared before you submitted your Revocation Notice.
- You have the right to inspect and/or copy (at your expense) your Protected Information, subject to approval of your treatment provider(s). Your Protected Information may still be disclosed when permitted or required by law2, whether or not you sign or subsequently revoke this Authorization.
- Protected Information disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. The following statement will accompany your record on CHN MSS: “42 C.F.R. Prohibits unauthorized disclosure of these records.”
- A photocopy or electronic copy of this signed Authorization is as effective as the original.

AUTHORIZATION

I hereby authorize and grant permission to the BrazCo Resource Network, to use and disclose my Protected Information to other organizations on the Network for the Purpose. I understand that my care team includes organizations that participate in the Network. These organizations may include my educators; my past, current, and future treating providers; and law enforcement who provide emergency response service. I understand that by signing below, I am separately consenting to the sharing of Protected Information from each Category, if such information exists.

By signing below, I acknowledge that I have read and that I understand this Authorization form, and my rights with respect to my Protected Information. I also acknowledge a copy of this Authorization form is available upon request.

Signed:	BENITO SANTIBANEZ
Printed name:	BENITO SANTIBANEZ
Date:	2024-02-15

Relationship

Self:	Self
Parent / Guardian of Minor Child (Under 18):	
Guardian / Conservator of Adult Client:	