WHOLE PERSON CARE (WPC) PROGRAM
AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

ochealth CARE AGENCY

The Whole Person Care program is designed to improve health outcomes by coordinating care among participating entities through information sharing. Your authorization to allow WPC participating entities to have access to information pertaining to you and your care is required to enroll into WPC. For more information about the WPC program, please visit: ochealthinfo.com/wpc.

PART 1: CLIENT/PATIENT INFORMATION

Client/Patient Last Name	Client/Patient First Name	Middle Initial	Date of Birth

Email	CIN#	MRN	Telephone Number with Area Code

Address	City	State	Zip

PART 2: PARTICIPATING ENTITIES WHO WILL DISCLOSE THIS INFORMATION

Whole Person Care Program			Address: 405 W. 5th Street, Suite 445
City: Santa Ana	State: CA	Zip: 92701	Telephone Number with area code: (714) 834-5891

PART 3: PARTICIPATING ENTITIES WHO WILL RECEIVE THIS INFORMATION

Whole Person Care Program			Address
City	State	Zip	Telephone Number with area code

PART 4: PURPOSE OF THIS AUTHORIZATION

Coordination of Care with and between the Whole Person Care Program participating entities.

PART 5: INFORMATION THAT CAN BE RELEASED *(Section 5B Optional)*

A. The minimum amount of information to coordinate care between the Whole Person Care participating entities.

B. To share HIV/AIDS Testing and Results is optional. Initial below if you agree to share with the WPC participating entities. X_____

PART 6: DATE YOUR AUTHORIZATION EXPIRES

Unless otherwise revoked in writing, this authorization expires upon: The earlier of: Disenrollment from the WPC Program OR 12/31/2020

FOR YOUR REVIEW

I have read the contents of this form. I understand, agree, and allow the County of Orange Whole Person Care (WPC) to use and release my information as I have stated above. I also understand that signing this form is voluntary and, with the exception of participation in the WPC program, treatment, payment or eligibility for benefits will not be affected if I do not sign this authorization. I have the right to revoke this authorization at any time in writing by sending a notice to the WPC Program Administrator. The revocation will not affect disclosures the WPC program has already made in reliance on the authorization. Information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by federal privacy law (HIPAA). Applicable State or other federal law may require the recipient to obtain your written authorization before re-disclosure unless otherwise permitted by such laws. I am entitled to a copy of this form. Fees may apply to certain requests. A copy of the original authorization is valid.

PART 7: SIGNATURE - PARTICIPANT OR DESIGNATED PERSONAL REPRESENTATIVE/GUARDIAN	PART 8: DATE
X	

Personal Representative (Print full name)	Personal Relationship to Client / Patient (e.g. conservator, parent, etc.)		
Personal Representative Street Address	**City**	**State**	**Zip**

Disclosures pursuant to this authorization are allowable only among Whole Person Care participating entities
All numbered items must be completed for authorization to be valid