Assistance in Community Integration Services Participant Information Release Form

The pilot Assistance in Community Integration Services ("ACIS") Program is operated by the Prince George's County Department of Health through the collaborate efforts and delivery of health and social services provided by participating local, State and Federal providers (collectively the "Partner Entities"). Funding for the ACIS Program is provided to the Partner Entities to specifically improve the health outcomes for Maryland Medicaid beneficiaries at risk of institutional placement or homelessness and who meet specific needs-based health criteria ("Participant" or "Participants").

To provide the most effective and efficient care and ACIS Program services, it is important that the Partner Entities have the ability and authorization to share important personal, medical and other information ("Information") about you. Specifically, any Information you share or Partner Entities collect about you will be kept in a secure electronic case record that can be viewed by ACIS Partner Entities and any other provider deemed necessary by the Prince George's County Health Department to ensure your access to appropriate ACIS Program services. The Information that may be collected and shared about you includes, but is not limited to, the following:

- Personal History
- Demographic Information
- Family History
- Financial Information
- Criminal History
- Housing
- Benefits/Services Needed, Planned or Received
- Medical Diagnosis and Records
- Mental/Behavioral Health Diagnosis and Records
- HIV/AIDS

Your Information will be communicated to the Prince George's County ACIS Program, Partner Entities, and other relevant providers using the HMIS computer system in several ways, one of which will include communication through a computer-based system that uses telephone lines to send and receive information. The highest level of security measures will be used to protect the information sent and received by telephone. Only authorized personnel will be able to view your personal information.

By signing below, I agree to participate in the ACIS Program and authorize a free exchange of my personal, medical and other information ("Information") between ACIS Partner Entities and other relevant providers for a period of one (1) year to provide ACIS Program services. Furthermore, I understand that the ACIS Partner Entities cannot disclose my Information without my written consent unless the release of such Information is required pursuant to applicable local, State and Federal laws.

If I choose to withdraw this authorization to participate in the ACIS Program and release of Information, I understand that the ACIS Partner Entities and other relevant providers must stop sharing information that relates to my participation and or any services that I received through the ACIS Program.

____________________________ ____________________________
Print Name Social Security Number

____________________________ ____________________________
Signature Date

____________________________ ____________________________
Witness Date