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SAMPLE CONFIDENTIALITY AGREEMENT AND CONSENT FOR DATA SHARING BETWEEN DV AND HEALTHCARE PARTNERSHIPS

This is a simple, sample agreement for obtaining client/patient consent for DV and healthcare partnerships to share limited protected health information with each other on matters related only to referral outcomes, appointment status and reminders, pertinent follow up, and other items pertaining to a client's **access** to care and services. It does not give consent to share medical information, diagnoses, test results, etc., but rather helps to create a feedback loop between partners in order to document referral outcomes, should partners decide to do this.

SAMPLE CONFIDENTIALITY AGREEMENT AND PATIENT CONSENT

(to be implemented at healthcare partner site, where consent will be obtained)

With my consent, [healthcare organization name] may share protected information with [DV organization name] only about referrals and appointments made, appointments completed or failed, and any follow up appointments made in order to help carry out my access to care and services.

Information about lab test results, diagnosis, treatment, procedures, and other medical care or services accessed may not be shared with [DV organization name].

By signing this form, I am consenting to [healthcare organization name's] use and disclosure of the protected and limited referral and appointment information listed above with [DV organization name].

I may revoke my consent in writing except to the extent that [healthcare organization name] has already made disclosures in reliance upon my prior consent.

_____	_____
Patient Signature	Witness
_____	_____
Patient Name (printed)	Date
	Patient Record Number

SAMPLE CONFIDENTIALITY AGREEMENT AND PATIENT CONSENT

(to be implemented at DV program partner site, where consent will be obtained)

With my consent, [DV organization name] may share protected information with [healthcare organization name] only about referrals and appointments made, appointments completed or failed, and any follow up appointments made in order to help carry out my access to care and services.

Information about lab test results, diagnosis, treatment, procedures, and other medical care or services accessed may not be shared with [DV organization name].

By signing this form, I am consenting to [DV organization name's] use and disclosure of the protected and limited referral and appointment information listed above with [healthcare organization name].

I may revoke my consent in writing except to the extent that [DV organization name] has already made disclosures in reliance upon my prior consent.

_____	_____
Client Signature	Witness
_____	_____
Client Name (printed)	Date
	Client Record Number