BREATHE EASY AT HOME PROJECT

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

HEALTH CARE PROVIDER

WE ARE ASKING YOU TO ALLOW US TO FORWARD INFORMATION ABOUT YOU AND YOUR CHILD TO THE BREATHE EASY AT HOME PROJECT.

The Breathe Easy at Home project is a collaboration between several state and city agencies, including primary care providers, local housing code enforcement, the Rhode Island Department of Health, Rhode Island Center for Law and Public Policy's Medical Legal Partnership for Children, and the Rhode Island Center for Justice.

This program is designed to enhance communication between medical providers, public health agencies, and housing agencies with the goal of improving housing conditions for children with asthma.

WHAT DOES IT MEAN TO FORWARD INFORMATION ABOUT MY CHILD TO THE BREATHE EASY AT HOME PROJECT?

- Through this project, you and your family will be given priority to get a housing inspection.
- The Breathe Easy at Home project team may discuss the nature of your family's health, how housing conditions may be contributing to asthma/respiratory incidents in your home, and whether and how the Breathe Easy at Home project may further help your family.
- If you sign this form, you agree to let us share your contact information and information about possible asthma triggers in your home to the city/town housing code office that will conduct the home inspection, and to share that same information with the Rhode Island Department of Health's Asthma Control Program, and its partners that strive to help children and their families who are affected by asthma

WHAT INFORMATION WILL BE SHARED WITH THE BREATHE EASY AT HOME PROJECT?

The information shared will include:

- Name, address, and phone number
- Other information related to housing problems that could affect asthma

TAKING PART IN THE BREATHE EASY AT HOME PROJECT IS VOLUNTARY.

- Your participation is completely up to you. You do not have to agree to let us identify you or refer you to receive a home inspection. Your decision to participate (either yes or no) will not affect your ability to get healthcare, your enrollment in any health plan, or your healthcare benefits.
- You have a right to get a copy of this form. If you sign this form, you agree to let us use or share your information as described in the section above.

PATIENT NAME (PRINT)	PATIENT DATE OF BIRTH
DATE	SIGNATURE (PATIENT OR AUTHORIZED REPRESENTATIVE)
AUTHORIZED REPRESENTATIVE NAME (PRINT)	RELATIONSHIP TO PATIENT (PARENT, GUARDIAN)