

## ENROLLMENT IN THE MCN HEALTH NETWORK

Enrolling Clinic		Clinic phone number(s)	
E-mail address		Clinic fax number(s)	
Contact person at Clinic			
Security Question #1:	Patient's city of birth?		
Security Question #2:	Patient's father's first name?		
Please indicate the health area(s) for which the participant is being enrolled. If the participant's health status changes during enrollment in the Health Network, additional areas may be added with the participant's verbal consent.		<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Prenatal Care <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV <input type="checkbox"/> General Health

## CONSENT FOR RELEASE OF MEDICAL INFORMATION

First Name	Last Name(s)
Alias, Nicknames, Etc	Birth Date (Month / Day / Year)

The Health Network currently helps with continuity of care for people with infectious chronic illnesses or other healthcare concerns. (i) MCN is a non-profit company coordinating my enrollment in the Health Network at no cost to me; (ii) MCN may not be able to obtain health care providers that are available to care for my condition at no cost to me; (iii) the health care providers who will be providing my treatment are independent and not employees of MCN; and (iv) MCN does not provide, and is not responsible for, any health care treatment, or the outcomes of such treatment, in connection with any or all of the Health Network projects.

I agree to participate in the Health Network, and I understand that my protected health information and personal information will only be released for the purposes of my medical treatment, healthcare operations, payment, or pursuant to my authorization.

I do NOT authorize MCN or future health care providers to have access to my medical records around issue(s) listed here:

*(attach additional page if needed)*

**I agree to notify my future health care providers of my enrollment in the MCN Health Network to help facilitate the transfer of my medical records.** I understand and consent to MCN maintaining records for me containing sensitive health information (examples: HIV status and/or information about mental health issues) if my health care provider believes this information is needed for my treatment. I authorize MCN and future health care providers to have access to those medical records that my health care providers feel are necessary for my medical treatment and/or continued screening.

Authorized individuals from MCN may contact me by phone, mail or in person regarding follow up and referral for my treatment for these conditions. These individuals will adhere to federally mandated confidentiality, privacy and security procedures. **This consent form will remain in effect for two years (24 months) from the date signed** or until my participation in the Health Network has ended for another reason. I can submit a written request any time to leave the Health Network or to limit the health issues that MCN is authorized to address. I also understand that I have a right to receive a copy of my medical records on file with MCN upon written request.

I HEREBY RELEASE MCN, ITS EMPLOYEES, OFFICERS, DIRECTORS, CONSULTANTS, REPRESENTATIVES, SUCCESSORS, AND ASSIGNS FROM AND AGAINST ANY AND ALL CLAIMS, CAUSES OF ACTIONS, DAMAGES, LOSSES, EXPENSES (INCLUDING ATTORNEYS' FEES), AND LIABILITIES OF ANY KIND WHATSOEVER ARISING OUT OF MY ENROLLMENT IN THE HEALTH NETWORK AND MY HEALTH CARE TREATMENT RESULTING FROM MY ENROLLMENT IN THE HEALTH NETWORK.

**\*REQUIRED**

<b>*PARTICIPANT SIGNATURE</b> (or Signature of Legal Representative)	Date
Relationship of Legal Representative to Patient	Witness Signature

*We recommend that, whenever possible, you provide the participant with a copy of this Consent for Release of Medical Records and MCN Health Network Enrollment form when it is completed.*

ENGLISH –THIS CONSENT FORM IS VALID FOR 2 YEARS AFTER DATE OF SIGNATURE

*Please contact us at 512-327-2017 or [www.migrantclinician.org/network](http://www.migrantclinician.org/network) for more information on the MCN Health Network.*

## PARTICIPANT INFORMATION SHEET | MCN HEALTH NETWORK

**\*REQUIRED**

First Name		Last Name(s)	
Mother's Maiden Name		Birth Date (Month / Day / Year)	
Place of birth:	City	Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male
	State	Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other: <input type="checkbox"/> Married <input type="checkbox"/> Widowed
	Country		
Race/Ethnicity:	<input type="checkbox"/> White – Non-Hispanic/Latino <input type="checkbox"/> Asian – Non-Hispanic/Latino	<input type="checkbox"/> Black – Non-Hispanic/Latino <input type="checkbox"/> Indigenous	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other:
Language(s) Spoken:	<input type="checkbox"/> English <input type="checkbox"/> Creole <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	Language you prefer to be contacted in:	
Occupation(s) (from past two years):	<input type="checkbox"/> Farmworker	<input type="checkbox"/> Construction	<input type="checkbox"/> Retired
	<input type="checkbox"/> Homemaker	<input type="checkbox"/> Factory	<input type="checkbox"/> Unemployed
	<input type="checkbox"/> Student	<input type="checkbox"/> Child care	<input type="checkbox"/> Other:
Current Residence:	<input type="checkbox"/> Farmworker Camp Housing <input type="checkbox"/> Home	<input type="checkbox"/> Jail <input type="checkbox"/> ICE Detention Center	<input type="checkbox"/> Homeless <input type="checkbox"/> Other:

### CURRENT CONTACT INFORMATION FOR PARTICIPANT:

	Street / P.O Box	City	State	Zip/Country
<b>*PHYSICAL ADDRESS:</b>				
<b>*MAILING ADDRESS:</b>				
<b>*PHONE NUMBER</b> (with Area Code) HOME / CELL / WORK:	Is it ok if we talk to people that answer this phone about your personal health information? <i>(if you do not check off either box, or you do not initial, your answer will be "No")</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>*INITIALS:</b>

### OTHER CONTACT INFORMATION FOR PARTICIPANT (Place you normally move to):

	Street / P.O Box	City	State	Zip/Country
Physical Address:				
Mailing Address:				
<b>*PHONE NUMBER</b> (with Area Code) HOME / CELL / WORK:	Is it ok if we talk to people that answer this phone about your personal health information? <i>(if you do not check off either box, or you do not initial, your answer will be "No")</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>*INITIALS:</b>

**Additional Contact:** Please list someone we can contact if we cannot reach you at either of the locations you provided. In doing this you give MCN permission to contact that family member or friend to assist you in receiving continued health care, which may require discussing your health condition(s) with this individual. You do not have to provide this additional contact information.

First Name	Last Name	Relationship to Participant
Street / P.O Box	City	State
		Zip/Country
<b>*PHONE NUMBER</b> (with Area Code) HOME / CELL / WORK:	Is it ok if we talk to people that answer this phone about your personal health information? <i>(if you do not check off either box, or you do not initial, your answer will be "No")</i>	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>*INITIALS:</b>