All Hands Health Network
Consent and Authorization to Share Information

Instructions: *Please read all information on this form before you sign it. You are receiving this form because you are being invited to participate in the All Hands Health Network ("AHHN"). Ann & Robert H. Lurie Children's Hospital of Chicago ("Lurie Children's") is the main organizer of the AHHN. This form explains how the participant's health information will be shared with AHHN providers. Participants aged 12-17 years must also sign this form.*

Consent to participate: You agree to participate in the AHHN for resource coordination services. The AHHN Providers will use your health information to connect you to services and resources, make referrals, and do other health care related activities. The activities may also include services to help manage your care.

Recipients of Information: The AHHN is a network of clinical providers, service providers, service navigators, and community resources ("AHHN Providers"). They have the goal of providing better care to you. The full list of AHHN Providers is here: https://allhandshealthnetwork.luriechildrens.org. The list of AHHN Providers may be updated as new services and resources are added.

Your Health Information: AHHN Providers will get health information about the participant. This information may include past medical treatment, family history, medical images, test results, immunizations and injuries. Your health information may also have information about: HIV/AIDS related health information; Sexually Transmitted Illness information; Sexual Assault/Abuse information; Birth Control information; Pregnancy information; Child Abuse/Neglect information; Behavioral and Mental health information; Drug/alcohol use information; and/or substance use treatment program information. AHHN Providers will share the health information via secure electronic data sharing systems provided by Lurie Children's. AHHN Providers may also use I-CARE. I-CARE is program by the Illinois Department of Public Health to share vaccine information with medical providers.

Expiration: This Authorization will expire December 31, 2027, unless taken back by you earlier. You have the right to revoke (take back) this Authorization at any time. To revoke (take back) the Authorization, I can contact allhands@luriechildrens.org or _____phone___________________. Taking back your Authorization may limit your ability to participate in the AHHN. If you take back your Authorization, it will not apply to information that has already been shared and used. Your providers can use your health information for billing purposes.

Authorization to Share Information: You are being asked to sign this form because it will help AHHN Providers coordinate access to resources. AHHN Providers may share your information with other non-healthcare resources that may provide you other services. Once shared, some information may not be protected by privacy laws. But, Illinois law does not allow healthcare providers to share sensitive health information like AIDS/HIV, genetic testing, mental health and developmental disabilities information except in certain situations. Your AHHN Providers may receive payment from a third party in connection with the use of your health information. You have the right to inspect and obtain a copy of information about mental health, drug and alcohol, or developmental disability services that is disclosed according to this Authorization. If you do not sign this form, it will limit your ability to participate in the AHHN.

Notice to Individuals Receiving Substance Use (Alcohol, Drug Abuse) and/or Mental Health Information:

The confidentiality of alcohol and drug abuse patient records and/or mental health records disclosed to you pursuant to this authorization is protected by Federal law and regulations and by the Illinois Mental Health and Developmental Disabilities Confidentiality Act. Generally, you may not further disclose the identity of the patient, or any information identifying the patient as an alcohol or drug abuser, or recipient of mental health services, unless: (a) the patient consents in writing; (b) the disclosure is allowed by a court order; or (c) the disclosure is made to medical personnel in an emergency care situation or to qualified personnel for research, audit, or program evaluation purposes. Violation of Federal laws or regulations is a crime.

Electronic Signature: By typing my name below, I agree that:

- I read this form
- I am agreeing to participate in the All Hands Health Network ("AHHN") for resource coordination services
- I am authorizing the use of my information as described
- If I have questions, I understand that I can call _____phone__________________ for more information.
- The AHHN Providers (listed at https://allhandshealthnetwork.luriechildrens.org) may share my health information with each other as described in this form

Parent/Guardian: [TYPED NAME]
By typing my name above, I attest I am the parent/guardian, and I am signing on my own behalf.

Participant ages 12-17 years old: [TYPED NAME]
By typing my name above, I attest I am the participant, and I am signing on my own behalf.