Dignity Health

SACRAMENTO COVERED
YOUR HEALTH, OUR MISSION.

Patient Health Navigation Program
Authorization to Release Health Care Information

As a follow-up to your Emergency Department visit, you may be eligible to receive FREE assistance in scheduling an appointment with your Primary Care Provider OR if you do not have a primary doctor, you can receive help finding one.

Please complete and sign this form to allow a Sacramento Covered Patient Navigator to follow-up with you to determine your health needs and assist you in obtaining the appropriate care you need in your community.

PT NAME: _____ DATE OF BIRTH: _____

PRIMARY LANGUAGE: _____ PRIMARY TELEPHONE #: _____

MEDICAL RECORD #: _____ <u>HEALTH NET GMCP INSURANCE:</u> ❑ YES ❑ NO

AUTHORIZED REPRESENTATIVE: _____ RELATIONSHIP TO PT: _____

ADDRESS:_____

CITY: _____ COUNTY: _____ ZIP: _____

EMAIL ADDRESS:_____

The Patient Health Navigation Program is a collaboration between Dignity Health's Sacramento Service Area Hospitals (General, Folsom, Methodist, and San Juan) and Sacramento Covered. As a participant in the Patient Navigation Program, a Navigator employed by Sacramento Covered may contact me to provide assistance in the community that meets my needs and circumstances. The Navigator may obtain my health information and share it with the clinic or provider that I am referred to. I understand that this authorization is voluntary, and that I may revoke it at any time in writing. Signing this authorization does not affect my ability to obtain treatment at any Dignity Health/Mercy hospital.

_____   _____
SIGNATURE OR MARK OF INDIVIDUAL   **DATE**

_____   _____   ❑ CHECK IF PT
AUTHORIZED REPRESENTATIVE   **RELATIONSHIP TO PT**   **IS A MINOR**

This authorization expires _____ (date or event). Authorization will expire in one year if not otherwise specified.

TO BE COMPLETED BY PATIENT NAVIGATOR --	Hospital: ❑ MHF ❑ MSJ ❑ MGH ❑ METH
Date of log entry: _____	Contact Method: ❑ FACE-TO-FACE ❑ PHONE