**County of San Luis Obispo - Public Health Department**

**Consent to Participate in Whole Person Care Pilot Project**

By providing consent, you agree to participate in integrated and case management services provided by the coordination of the Whole Person Care (WPC) Pilot Project.

* I understand that services include evaluation, assessment, referral and treatment by various health care providers and other specialists, including staff from social services and housing services.
* I understand that the WPC team may also help me determine my eligibility or continued eligibility for assistance or benefits, to determine my readiness/ability to participate and ensure the provision and coordination of health care services I may need, including physical health, dental and vision, mental health or substance use disorder services, housing, health education, as well as other ancillary supports that are appropriate to my specific needs.
* I understand that communication, collaboration, and integration among the various providers who make available healthcare and other services to me enhances the probability of my success and guarantees that I will be able to benefit from all appropriate services that might be available and offered.
* I understand that the services provided are confidential and that my privacy is protected under State and Federal laws that limit how my information may be used for services.
* I understand that I will be asked for my permission (authorization) before certain confidential information is shared with members of the team and/or with others, and that unless a law permits or requires a use or disclosure of my information it will not be used or disclosed unless I provide permission.
* I understand that the WPC Pilot Project routinely performs certain administrative activities, including review of outcomes and quality oversight by administrative staff that oversees the management of the project.
* I understand that I may change your mind about receiving services from this project and can discuss any concerns about my participation with the WPC Pilot Project staff at any time.
* I understand and acknowledge that notice of privacy practices was offered to me.

**Your signature on this form indicates that:**

You have read and understand the information provided in this form.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 (patient/legal representative)

If signed by a person other than the client, please indicate relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (legal representative)