



Project HEART
(Health Enrichment And Resource Training)

HEART PACKET

What is Project HEART?

- Project HEART offers FREE education classes for people 16 years and older with a developmental disability living in St. Charles County.
- Classes focus on health related topics such as cooking and nutrition, exercising, relationships and much more.
- We want to know what you've learned in class, so we ask five easy-to-answer questions before and after class. Assistance is provided, as needed. Don't stress though, it's our job to make you look smarter by the end of the class!
- Monthly calendars are developed and distributed a month before classes are to be held. Topics, days of the week and times vary each month.
- Calendars are distributed by e-mail or can be found at www.willowsway.org on the Project HEART page. A Participant Handbook and the latest HEARTbeat Newsletter can also be found on the Project HEART webpage. If you do not have access to a computer, please make Project HEART staff aware and we will be sure you get the information you need.

The Project HEART Philosophy

The Project HEART philosophy is that each of us learns best by doing and having fun. Each class is designed for everyone to participate, not just sit and listen. Because of the unique needs of each participant, classroom information and activities change to accommodate learning styles and abilities.

PROJECT HEART Staff

Sara Willis, Trainer

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In order to provide you with the inventive, fun and knowledgeable classes Project HEART offers, we must have important information about your learning needs and interests, releases for participation, permission to share information with our funding source (DDRb), as well as proof of eligibility for services. Please complete the forms provided for you in this packet and return to Project HEART.

The packet contains:

Project HEART Assessment & Consent

DDRb Client Information Release Form

Authorization for Disclosure of Consumer Medical/Health Information

3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility during the specified time frame.
4. This authorization becomes effective on _____ This authorization automatically expires on the following date, event or special condition _____
5. If I fail to specify an expiration date, this authorization will expire in one year.
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **in writing** and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **not** be affected.
7. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**
8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.
9. **THE FOLLOWING STATEMENT APPLIES TO ANY ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS THAT WE DISCLOSE:** Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

Signature of Consumer:		Date:	
Signature of Witness:		Date:	
Signature of Parent/ Legal Guardian/Representative:		Date:	

(Please include a Description of Authority to Act on Consumer's Behalf):

NOTICE OF REVOCATION

I, _____ (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

Signature of Consumer:		Date:	
Signature of Witness:		Date:	
Signature of Parent/ Legal Guardian/Representative:		Date:	

If you choose to revoke your authorization, please provide a copy of the completed revocation to the Health Information Management Director (Medical Records Director), or the Client Information Center, or to the Privacy Officer of this facility.