Senior PharmAssist Participant Consent

Mission: *Senior PharmAssist promotes healthier living for older adults living in Durham by helping them obtain and better manage needed medications and by providing tailored health education, Medicare insurance counseling, community referral, and advocacy. Senior PharmAssist is not a prescriber and does not prescribe medications.*

I certify that I am a Durham resident and I am 60 years or older in age. I understand that the eligibility interview and medication review will last about 1 ½ hours. If I qualify for financial assistance from Senior PharmAssist, I acknowledge that I understand and agree to the following:

1. Senior PharmAssist may contact other social service agencies or state agencies, and healthcare insurers in order to verify my eligibility for the program.

2. I will share information with Senior PharmAssist related to my financial eligibility for Senior PharmAssist and Medicare prescription drug subsidies, if applicable.

3. Senior PharmAssist and participating pharmacies may share information concerning my medication use and health status (protected health information) with each other, my doctor or other health care providers, my caregiver, and permitted emergency contacts listed on the back of this form. This may include sharing or gathering information via electronic health records.

4. Senior PharmAssist may contact the persons I list on this form as my emergency contacts if the staff cannot get in touch with me, or are concerned about my well-being.

5. Senior PharmAssist needs at least 24 hours notice of appointment cancellation. Two or more cancellations or unkept appoinments may disqualify me for Senior PharmAssist's financial assistance.

6. Information gathered about me at Senior PharmAssist is considered a medical record. I have the right to ask for a correction in the medical record on file at Senior PharmAssist and I may also request a copy of this medical record. Senior PharmAssist has 30 days to respond to my request. I understand that I will be asked to reimburse Senior PharmAssist if I request a copy of my medical record.

7. Senior PharmAssist may use information gathered in interviews, medication reviews, and in electronic health records for its program and reports. My name will be kept confidential and will not be used in public reports. Information will be used only for healthcare purposes and possible reimbursement.

8. If I feel that my protected health information has been shared without my permission for purposes other than treatment, payment or continuing healthcare operation, I can file a complaint with

SIGN ON BACK ➔

Senior PharmAssist and/or the U.S. Office of Civil Rights - www.hhs.gov/ocr/hipaa or call (866)627-7748; US DHHS, 200 Independence Ave, S.W., Room 509F, HHH Building, Washington, DC 20201.

9. I will be given a copy of this signed consent form for my records.

Participant's Signature ______________________ Caregiver's Signature ______________________

Print Name ______________________ Caregiver Print Name ______________________

Date: ______________ Staff/ Witness ______________________

Emergency Contact(s)

Name	Phone	Relationship	Decline Sharing PHI	Legal POA? Health POA?
			☐	☐
			☐	☐
			☐	☐

Updated Sept 2023