ThriveNV Patient Navigation Consent and Confidentiality Agreement

I consent to receive Patient Navigation services ("Services") from a Nevada Cancer Coalition Patient Navigator ("PN") through the ThriveNV Patient Navigation program at no cost to me. I will allow the PN assigned to me to assess my needs and collect personal and medical information about me to provide Services. This information will be saved within secure patient navigation software and shall be considered Confidential Information.

For purposes of this Agreement, "Confidential Information" means any information concerning one of the parties (the "Provider") whether prepared by that party, its representatives or otherwise, regardless of the form or format in which communicated, which is furnished to the other party (the "Recipient") or its representatives, now or in the future, by or on behalf of the Provider, and shall include, among other things, all medical information, notes, analyses, compilations, studies, interpretations or other documents prepared by the Recipient or its representatives which contain, reflect or are based upon, in whole or in part, the information furnished to the Recipient or its representatives by the Provider or its representatives pursuant hereto, except for any such information:

a) that is or becomes generally available to the public other than as a result of disclosure by the Recipient or any party to whom the Recipient has disclosed such information;

b) that is obtained by the Recipient on a non-confidential basis from a third party entitled to disclose such information; or

c) that is already known by the Recipient at the time such information is received by the Recipient; provided that no information will be deemed to be within any of these exceptions merely because (i) it is included in broader or general information known to the public or the Recipient; or (ii) one or more narrower or less general facts or concepts included in such information are known to the public or the Recipient.

I understand that:

- Services focus on providing education, support, and referral assistance to community resources (which may include: transportation, financial, counseling, support groups, wig resources, etc.).
- Any outside service ("Referral Service") provided by NCC or PN does not guarantee a particular result of the Referral Service. NCC and PN make no express or implied warranty as to the Referral Service, including, without limitation, any outcome of Referral Service, or my acceptance into any Referral Service program.
- I agree to indemnify and hold harmless NCC, its agents, officers, directors, board members, employees, PN, contractors and suppliers for any loss, damage, claims, cause of action, cost or expense (including attorneys' fees) arising or resulting from (i) any failure of NCC's obligations of this Agreement, or (ii) any services provided by NCC, PN or referral providing Referral Service.

- Contact between me and my PN may be via phone, video conference (if needed), or email.
- PN may help educate me about my cancer diagnosis, which may include: explanation/clarification of medical terminology and information received from my doctor, nurse, social worker, and other individuals involved in my cancer treatment ("Care Team"), identifying questions I can ask my doctor, or answering questions about types of treatment recommended by my Care Team.
- PN will NOT deliver diagnoses, provide medical advice, nor notify me of any medical-related results including imaging or lab work. I understand that this type of medical information is the responsibility of my Care Team.
- I agree to take every precaution necessary to protect my health and safety. I will participate in accordance with all safety rules and safe operational procedures of NCC and PN. I recognize that participation may be subjected to potential risks, illnesses and injuries.

I authorize NCC and my PN to speak to the following person(s) about my care.

_____ _____

Name & relationship to you *(family, caregiver, etc.)* Phone Number

_____ _____

Name & relationship to you *(family, caregiver, etc.)* Phone Number

■ Yes ❑ No My PN can contact members of my Care Team to obtain medical information specific to my cancer diagnosis/treatment/plan of care for the purposes of providing Services and/or creating a summary of care. (If yes, please complete the Authorization for the Release of Protected Health Information.)

I understand the Services provided by the Program and give my consent to receive the Services.

_____ _____

Client Name (print) Phone Number

_____ _____

Client Signature (type again if digital) Date

CLICK TO EMAIL COMPLETED FORM

SEND FORM NOW

Form will not send? Please read instructions below.

▪ Please print a copy of this Agreement for future reference.

If your version of Adobe Acrobat (or PDF reader) will not send the form, please follow these steps:

1) Save this PDF to your computer desktop. We recommend keeping the file name for simplicity. *(ThriveNV-Patient-Consent-Agreement.pdf)*

2) Once saved, open your email application (Gmail, Outlook, Hotmail, etc.) and create an email addressed to **PN@THRIVENV.ORG**

3) Attach the completed PDF to the email message and send. A patient navigator will be in contact with you within 2 – 3 business days.

Thank you and we look forward to talking with you soon.