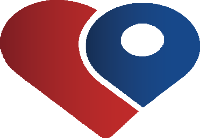
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Insert Your Logo Here

**Consent to Participate in the *My Health GPS* Program**

**(English)**

**Please read all the information on this form before you sign it.**

*My Health GPS* is a program offered by the District of Columbia Medicaid. It helps you get the care you need to be healthy. It is your choice to join the *My Health GPS* Program. If you do not want to join, you will still get your Medicaid services.

**How *My Health GPS* Partners work together**

A big part of *My Health GPS* is making sure hospitals and any of your health care providers work as partners to better care for you. If you join the program, your health information may be shared with hospitals and providers that care for you. This could include information from the past or in the future within your health record.

**Right to privacy**

Your health information is private. It cannot be given to other people unless they follow the law. All health care or community service providers who can see your health information must obey all these laws. They cannot share your information unless you agree, or the law says they can give the information to other people. This is true even if your health information is on a computer system or on paper.

By signing this form, I consent toparticipate in *My Health GPS.* I agree to actively participate, and I understand that I can change my mind.

**I have read and understand the information in this document and was given the chance to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost.**

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Participant’s Name (please print) Date of Birth

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Participant’s Signature Today’s Date

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Parent/Guardian/ Legal Rep Signature (If Applicable) Today’s Date