Care Coordination – Information Sharing Consent Form

By signing this form, you agree to participate in the _____ **Care Coordination Program.**
Print name of Qualified Health Home

When you are enrolled in a Health Home, your health care providers and other people involved in your care need to be able to talk to each other about your care. They also need to share information with each other in order to give you better care. If you agree and sign this form, the Health Home and the providers/partners that you have listed on page two of this form are allowed to obtain, read, copy, and share with each other your health information in order to coordinate your care.

NOTE: If your health records include any of the following information, you must also complete this section to include these records. I give my permission to disclose the following records (check all that apply):

☐ Mental health ☐ HIV/AIDS and STD test results, diagnosis, or treatment

Note: To give consent for the release of confidential alcohol or drug treatment information you must complete a separate Release of Information (ROI) for Chemical Dependency (CD) Services form.

- This consent is valid: ☐ as long as my Health Home needs my records for this program, or ☐ until _____ (date or event).
- I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.
- A copy of this form provides my permission to share records.

Your health information is private and cannot be given to other people without your permission under State and Federal laws and rules. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The providers/partners that can get and see your health information must obey all these laws. They cannot give your information to other people unless you agree or the law says they can give the information to other people. This is true if your health information is on a computer system or on paper.

☐ **I agree** that my Health Home can obtain all of my health information from the providers/partners listed on this form to coordinate my care. I also agree that the Health Home and the providers/partners listed on this form may share my health information with each other, and other providers/partners involved in managing my care. I understand this Consent Form takes the place of any other Health Home Information Sharing Consent Forms I may have signed before. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form and giving it to my Health Home.

_____ _____
Print name of beneficiary | Beneficiary's date of birth

_____ _____
Signature of beneficiary or beneficiary's legal representative | Date

_____ _____
Print name of legal representative (if applicable) | Relationship of legal representative to beneficiary

Print name of beneficiary _____

Behavioral Health Providers – *List the name of providers who provide Mental Health or Alcohol and Drug Services.*	Beneficiary Gives Consent		Beneficiary Withdraws Consent	
	Date	Initials	Date	Initials

This information includes the following:

- ☐ Assessment, Treatment Plan, Progress Notes, Diagnosis, and Prognosis
- ☐ Physical Health, Mental Health, and Substance Abuse treatment history including plan, details of participation, past and current health/mental/substance abuse condition
- ☐ Periodic reports to evaluate patient progress in treatment, including Court Reports
- ☐ Results and dates of drug tests
- ☐ Results of psychological or vocational tests
- ☐ Current medications
- ☐ Medical diagnoses
- ☐ Health Status
- ☐ Prognosis
- ☐ Medical/psychosocial history
- ☐ Results of medical/laboratory tests
- ☐ Physical Health, Mental Health and Substance Abuse Prescription/Pharmacy information
- ☐ HIV/AIDS Information
- ☐ Financial agreement/ Documents and payment information
- ☐ Attendance Reports
- ☐ Other: _____

Partners That Participate in Your Care Coordination – *May include housing navigator, Alta Regional, Probation, or other community based organization.* *This consent is limited to information necessary to coordinate services.*	Beneficiary Gives Consent		Beneficiary Withdraws Consent	
	Date	Initials	Date	Initials

This information includes the following:

- ☐ Provider Information – entity/name, location, phone, fax
- ☐ Appointment Information
- ☐ Medication
- ☐ Attendance Only Records
- ☐ Eligibility (type, expiration, health plan)
- ☐ Probation (Intake/Placement Officer, X-Ref)
- ☐ Other: _____

Details about the beneficiary information sharing and consent process:

1. **How will providers/partners use my information?**
   If you agree, providers/partners will use your health information to coordinate and help you manage your health care.

2. **Where does my health information come from?**
   Your health information comes from places and people that gave you health care or health insurance in the past. These may include hospitals, doctors, pharmacies, laboratories, health plans, and other groups that share health information. You can get a list of all the places and people by calling your care coordinator.

3. **What laws and rules cover how my health information can be shared?**
   These laws and regulations include state and federal regulations related to health care information sharing: HIPAA, 45 CFR Parts 160, 164, Subparts A&E; W&I Code 5328; 42 CFR Part 2.

4. **If I agree, who can obtain and see my information?**
   The only people who can see your health information are those you agree can obtain and see it, such as doctors and other people who work with a Health Home and who are involved in your health care. Other people giving you care can also see the information. When you get care from a person who is not your usual doctor or provider, such as a new pharmacy, hospital, or other provider, some information, for example, what your health plan pays for or the name of your Health Home provider, may be given to them or seen by them. For more information on who can get information, see our Notice of Privacy Practices.

5. **What if a person uses my information and I did not agree to let them use it?**
   If you think a person used your information, and you did not agree to give the person your information, call your case coordinator or call the xxx at 1-800-xxx-xxxx (TTY: 1-800-xxx-xxxx).

6. **How long does my consent last?**
   Your consent will last until the day you cancel your consent or leave the Health Home.

7. **How do I make changes to the list of providers/partners on the form?**
   You can add new names to the list at any time by adding the provider/partner information and filling out the "Beneficiary Gives Consent columns next to the addition. You can delete someone you no longer wish to include by filling out the Beneficiary Withdraws Consent columns next to the previously added provider/partner.

8. **What if I change my mind later and want to take back my consent?**
   You can cancel your consent at any time by signing a Health Home Information Sharing Withdrawal of Consent Form and giving it to your Care Coordinator. You can get this form online xxxx or by calling the xxxx toll-free line at 1-800-xxx-xxxx (TTY: 1-800-xxx-xxxx). Your care coordinator will help you fill out

this form if you want. **Note:** If you decide to cancel your consent, providers who already have your information do not have to give your information back to you or take it out of their records.

9. **When do I get a copy of this Health Home Information Sharing Consent Form?**
   You can have a copy of the form after you sign it.