

Print name of beneficiary _____

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

This information includes the following:

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Assessment, Treatment Plan, Progress Notes, Diagnosis, and Prognosis <input type="checkbox"/> Physical Health, Mental Health, and Substance Abuse treatment history including plan, details of participation, past and current health/mental/substance abuse condition <input type="checkbox"/> Periodic reports to evaluate patient progress in treatment, including Court Reports <input type="checkbox"/> Results and dates of drug tests <input type="checkbox"/> Results of psychological or vocational tests <input type="checkbox"/> Current medications <input type="checkbox"/> Medical diagnoses | <ul style="list-style-type: none"> <input type="checkbox"/> Health Status <input type="checkbox"/> Prognosis <input type="checkbox"/> Medical/psychosocial history <input type="checkbox"/> Results of medical/laboratory tests <input type="checkbox"/> Physical Health, Mental Health and Substance Abuse Prescription/Pharmacy information <input type="checkbox"/> HIV/AIDS Information <input type="checkbox"/> Financial agreement/ Documents and payment information <input type="checkbox"/> Attendance Reports <input type="checkbox"/> Other: _____ |
|---|--|

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

This information includes the following:

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Provider Information – entity/name, location, phone, fax <input type="checkbox"/> Appointment Information <input type="checkbox"/> Medication <input type="checkbox"/> Attendance Only Records | <ul style="list-style-type: none"> <input type="checkbox"/> Eligibility (type, expiration, health plan) <input type="checkbox"/> Probation (Intake/Placement Officer, X-Ref) <input type="checkbox"/> 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 xxx or by calling the xxx 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.

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