Care Coordination – Information Sharing Authorization Form

By signing this form, you agree to participate in _____**care coordination services**.
Print name of designated 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 ☐ Substance Use Disorders treatment ☐ HIV/AIDS and STD test results, diagnosis, or treatment

This authorization is valid: ☐ as long as I am enrolled in my health home, or

☐ until _____ (date or event).

If no box is checked, this authorization will expire in one year.

I may cancel or withdraw this authorization at any time in writing by sending notice to XXX, but that will not affect any information already shared.

I have a right to receive a copy of this form. My Health Plan may not require me to sign this form as a condition of treatment or coverage.

Your health information is private and cannot be given to other people without your permission under State and Federal laws and rules. 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 my 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 Authorization Form takes the place of any other information sharing authorization forms I may have signed before. I can change my mind and take back my authorization at any time by signing a Withdrawal of Authorization 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 Entity / Contact Information	Beneficiary Gives Authorization		Beneficiary Withdraws Authorization	
	Date	Initials	Date	Initials

Physical Health Information:

- ☐ Assessment, Treatment Plan, Diagnosis, and Medications
- ☐ Health Status
- ☐ Medical/psychosocial history
- ☐ Results of medical/laboratory tests
- ☐ Results and dates of drug tests

Mental Health Information:

- ☐ Assessment, Treatment Plan, Diagnosis, and Medications
- ☐ Prognosis
- ☐ Psychiatric history
- ☐ Results of medical/laboratory tests

Substance Use Disorders Information:

- ☐ Substance Use treatment history including plan, details of participation, past and current
- ☐ Periodic reports to evaluate patient progress in treatment, including Court Reports
- ☐ Results and dates of drug tests
- ☐ Attendance Reports

Other:

- ☐ HIV/AIDS Information
- ☐ Financial agreement/documents and payment information
- ☐ Other: _____

Partners That Participate in Your Care Coordination* Entity / Contact Information	Beneficiary Gives Authorization		Beneficiary Withdraws Authorization	
	Date	Initials	Date	Initials

This authorization is limited to the following items:

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

* *Partners that participate in your care coordination may include housing navigator, Alta Regional, Probation, or other community based organizations. Partner authorizations are limited to information necessary to coordinate services.*

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Details about the information sharing and authorization process

1. **What is the difference between providers and partners?**
   Providers include people who treat your physical health, mental health, or substance use disorder service needs. Partners help you with all other services.

2. **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.

3. **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 xxx.

4. **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.

5. **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.

6. **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 xxx or call the xxx at 1-800-xxx-xxxx (TTY: 1-800-xxx-xxxx).

7. **How long does my authorization last?**
   Your authorization will last until the day you cancel your authorization, leave your health home, or the date it has expired.

8. **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 Authorization" columns next to the addition. You can delete someone you no longer wish to include by filling out the "Beneficiary Withdraws Authorization" columns next to the previously added provider/partner.

9. **What if I change my mind later and want to take back my authorization?**
   You can cancel your authorization at any time by signing a Care Coordination Information Sharing Withdrawal of Authorization Form and giving it to your xxx. 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 xxx will help you fill out this form if you want. **Note:** If you decide to cancel your authorization, providers who already have your information do not have to give your information back to you or take it out of their records.

10. **When do I get a copy of this Care Coordination Information Sharing Authorization Form?**
    You can have a copy of the form after you sign it.