Authorization and Information Sharing Consent - Reentry Care Management

Washington State Health Care Authority

1 Information sharing consent

Your health information is private and cannot be given to other people unless you agree or applicable Washington State or federal laws allow the information to be shared. The providers/partners that can get and see your health information must obey all these laws. This is true if your health information is on a computer system or on paper. In addition to laws that apply to all types of health information, specific laws provide greater protection of information related to sexually transmitted diseases, mental health treatment, and substance use disorders.

I, _____ agree that _____
Client's first and last name *Provider/organization*
can obtain all my health information from the providers/partners listed on this form to provide coordination. I also agree that 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 can change my mind and take back my consent at any time by completing the **beneficiary withdraws consent** section on this form.

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 information to those specifically identified on pages 2-3. Initial all that apply and list your providers/partners on pages 2-3.

_____ Mental health

_____ HIV/AIDS and sexually transmitted disease (STD) test results, diagnosis, or treatment

For alcohol or drug treatment: To give consent for the release of confidential alcohol or drug treatment information, complete **Section 2: Release of information (ROI) for substance use disorder (SUD) services.**

This consent is valid (initial the appropriate choice):

_____ as long as my care manager needs my records for this program; or

_____ until the date or event of: _____

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.

Print beneficiary's first and last name	Beneficiary's date of birth
Beneficiary or beneficiary legal representative's signature	Date
Print legal representative's first and last name (if applicable)	Relationship to beneficiary

List your providers/partners on the following pages.

Print first and last name: _____

Providers/partners information

1. Provider/partner name: _____

   Beneficiary gives consent: _____ Date _____ Initials

   Beneficiary withdraws consent: _____ Date _____ Initials

   Information to be released. Check all that apply:

   - ☐ Assessment/screenings
   - ☐ Blood alcohol level
   - ☐ Demographics
   - ☐ Discharge summary
   - ☐ Education/training
   - ☐ Employment
   - ☐ HIV/AIDS, STD diagnosis/treatment
   - ☐ Lab & diagnostic tests
   - ☐ Medications
   - ☐ Mental health
   - ☐ Treatment status & recommendations
   - ☐ Urinalysis results
   - ☐ Other:

2. Provider/partner name: _____

   Beneficiary gives consent: _____ Date _____ Initials

   Beneficiary withdraws consent: _____ Date _____ Initials

   Information to be released. Check all that apply:

   - ☐ Assessment/screenings
   - ☐ Blood alcohol level
   - ☐ Demographics
   - ☐ Discharge summary
   - ☐ Education/training
   - ☐ Employment
   - ☐ HIV/AIDS, STD diagnosis/treatment
   - ☐ Lab & diagnostic tests
   - ☐ Medications
   - ☐ Mental health
   - ☐ Treatment status & recommendations
   - ☐ Urinalysis results
   - ☐ Other:

3. Provider/partner name: _____

   Beneficiary gives consent: _____ Date _____ Initials

   Beneficiary withdraws consent: _____ Date _____ Initials

   Information to be released. Check all that apply:

   - ☐ Assessment/screenings
   - ☐ Blood alcohol level
   - ☐ Demographics
   - ☐ Discharge summary
   - ☐ Education/training
   - ☐ Employment
   - ☐ HIV/AIDS, STD diagnosis/treatment
   - ☐ Lab & diagnostic tests
   - ☐ Medications
   - ☐ Mental health
   - ☐ Treatment status & recommendations
   - ☐ Urinalysis results
   - ☐ Other:

4. Provider/partner name: _____

Beneficiary gives consent: _____ Date _____ Initials

Beneficiary withdraws consent: _____ Date _____ Initials

Information to be released. Check all that apply:

- ☐ Assessment/screenings
- ☐ Blood alcohol level
- ☐ Demographics
- ☐ Discharge summary
- ☐ Education/training
- ☐ Employment
- ☐ HIV/AIDS, STD diagnosis/treatment
- ☐ Lab & diagnostic tests
- ☐ Medications
- ☐ Mental health
- ☐ Treatment status & recommendations
- ☐ Urinalysis results
- ☐ Other: _____

5. Provider/partner name: _____

Beneficiary gives consent: _____ Date _____ Initials

Beneficiary withdraws consent: _____ Date _____ Initials

Information to be released. Check all that apply:

- ☐ Assessment/screenings
- ☐ Blood alcohol level
- ☐ Demographics
- ☐ Discharge summary
- ☐ Education/training
- ☐ Employment
- ☐ HIV/AIDS, STD diagnosis/treatment
- ☐ Lab & diagnostic tests
- ☐ Medications
- ☐ Mental health
- ☐ Treatment status & recommendations
- ☐ Urinalysis results
- ☐ Other: _____

6. Provider/partner name: _____

Beneficiary gives consent: _____ Date _____ Initials

Beneficiary withdraws consent: _____ Date _____ Initials

Information to be released. Check all that apply:

- ☐ Assessment/screenings
- ☐ Blood alcohol level
- ☐ Demographics
- ☐ Discharge summary
- ☐ Education/training
- ☐ Employment
- ☐ HIV/AIDS, STD diagnosis/treatment
- ☐ Lab & diagnostic tests
- ☐ Medications
- ☐ Mental health
- ☐ Treatment status & recommendations
- ☐ Urinalysis results
- ☐ Other: _____

Annual consent review information

1. Annual consent review date: _____

Care manager's first and last name _____ Care manager's signature _____

2. Annual consent review date: _____

Care manager's first and last name _____ Care manager's signature _____

3. Annual consent review date: _____

Care manager's first and last name _____ Care manager's signature _____

This release of information should include **page 1 of the authorization and information sharing consent form** to provide the legal authority to release information for the beneficiary listed above. Attach additional pages as needed for release.

2 Release of information (ROI) for substance use disorder (SUD) services (as indicated on pages 2-3)

I, _____, _____,
Client's first and last name *Client's date of birth*

hereby authorize _____ to release to:
Provider/organization

1. Agency/provider name: _____

Agency/provider email address _____ Agency/provider phone number _____

2. Agency/provider name: _____

Agency/provider email address _____ Agency/provider phone number _____

3. Agency/provider name: _____

Agency/provider email address _____ Agency/provider phone number _____

To communicate with and disclose to one another the following information (nature of the information, as limited as possible):

Purpose of this release (enter reason, i.e., client request, coordination of services, payment of services, etc.):

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Specify the date, event, or condition upon which this consent expires (initital each category that applies):

_____ The date my public assistance/medical assistance benefits are discontinued; or

_____ Other. Specify earlier date if required by law: _____

Patient's signature	Date
Parent, guardian, or authorized representative's signature (if required)	Date

Notice prohibiting redisclosure of alcohol or drug treatment information

Prohibition on redisclosure of confidential information: This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is **not** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

3 Beneficiary information sharing and consent process frequently asked questions

How will providers/partners use my information?
Providers/partners will use your health information to coordinate and help you manage your health care.

Where does my health information come from?
Your health information comes from places and people that provided you health care or health insurance in the past. These may include hospitals, doctors, pharmacies, laboratories, health plans, the Washington Apple Health (Medicaid) program, and other groups that share health information. You can get a list of all the places and people by calling your care manager.

What laws and rules cover how my health information can be shared?
The laws and regulations that protect your health information include Chapter 70.02 RCW in Washington statute, the federal Health Insurance Portability and Accountability Act ("HIPAA"), and federal regulation 42 CFR Part 2.

If I agree, who can obtain and see my information?
Your information may be obtained or seen by the providers/partners you agree can obtain and see it. Information can also be obtained or seen when allowed by applicable laws. For example, 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, such as 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**.

What if a person uses my information and I did not agree to let them use it?
If you think a person inappropriately used your information, call your care manager or call the HCA Medical AssistanceCustomer Service Center (MACSC) toll-free line at 1-800-562-3022 (TRS: 711).

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** field next to the addition. You can delete someone you no longer wish to include by filling out the **beneficiary withdraws consent** field under the previously added provider/partner.

What if I change my mind later and want to take back my consent?
You can cancel your consent at any time by completing the **beneficiary withdrawal section** or contacting your care manager. 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.