COMMUNITY CARE
Behavioral Health Organization

Sometimes different providers take care of you. This may include both behavioral health and physical health providers. Without your *permission*, little information can be shared with providers. Providers and your health plan should work together to provide you with the best possible care. **Your permission is needed to share information about your use of substances, such as drugs and/or alcohol.**

What does it mean if I sign this form?
By signing this form, you are telling us that it is OK for your primary care provider, your specialists, your behavioral health care providers, and your health insurance plans (Listed in Part 2) to share health information about you for planning and coordinating your health care. This helps your providers and health insurance plans work together to take better care of you.

If you do not sign this form, your benefits will stay the same. If you have questions about your rights or if you need more details about how your health information is shared, please call the Health Care Concierge number on your managed care ID card or in your member handbook.

Why are you sharing this health information?
Sharing this information allows your providers and health insurance plans to better manage and coordinate your health care. Examples of how this information may help include (1) making sure the medications that you are taking are safe to take together, (2) coordinating the health care services you receive, and (3) making sure the health care you are receiving is helping to keep you healthy and well.

How long does my permission to share my health information last?
Your permission will last for one year from the date that you sign this form if your insurance coverage remains the same. You can cancel your permission at any time. This will not take back information that was already shared, but it will stop your health information from being shared any further unless you provide your permission again in writing. If you want to cancel your permission, you may do so in two ways:

1. By writing to the health plan that requested this form.
2. You can also cancel your permission verbally at any time.

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Part 1. Member Information

Last Name: ______________________ First Name: ______________________ Middle: __________

Medical Assistance ID (10-digits) or Insurance ID: ______________________

Date of Birth: *(mm/dd/yyyy)* [ ] Phone Number: *(no dashes)* [ ]

Address: ______________________

City: __________ State: __________ Zip Code: __________

Part 2. Provider Information

Insert the name, address and phone number of your providers, if applicable.

My Physical Health Insurance ***Plan*** Name: [ ]

My Behavioral Health Insurance ***Plan*** Name: [ ]

My ***Primary Care Provider (PCP)***: [ ]

My Behavioral Health ***Provider(s)***: [ ]

My other Health Care ***Specialist(s)***: [ ]

Other: [ ]

Part 3. Who can release my health information?

I agree that my physical health *plan* identified above in Part 2 may release my health information to the following entities:

My behavioral health *plan*: ◯ Yes ◯ No

My *primary care provider (PCP)*: ◯ Yes ◯ No

My behavioral health *provider(s)*: ◯ Yes ◯ No

My other health care *specialist(s)*: ◯ Yes ◯ No

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Part 3. Who can release my health information?

I agree that my behavioral health *plan* identified above in Part 2 may release my health information to the following entities:

- My physical health *plan*: ◯ Yes ◯ No
- My *primary care provider (PCP)*: ◯ Yes ◯ No
- My behavioral health *provider(s)*: ◯ Yes ◯ No
- My other health care *specialist(s)*: ◯ Yes ◯ No

I agree that my primary care provider (PCP) identified above in Part 2 may release my health information to the following entities:

- My physical health *plan*: ◯ Yes ◯ No
- My behavioral health *plan*: ◯ Yes ◯ No
- My behavioral health *provider(s)*: ◯ Yes ◯ No
- My other health care *specialist(s)*: ◯ Yes ◯ No

I agree that my behavioral health *provider(s)* identified above in Part 2 may release my health information to the following entities:

- My physical health *plan*: ◯ Yes ◯ No
- My behavioral health *plan*: ◯ Yes ◯ No
- My *primary care provider (PCP)*: ◯ Yes ◯ No
- My other health care *specialist(s)*: ◯ Yes ◯ No

I agree that my other health care *specialist(s)* identified above in Part 2 may release my health information to the following entities:

- My physical health *plan*: ◯ Yes ◯ No
- My behavioral health *plan*: ◯ Yes ◯ No
- My *primary care provider (PCP)*: ◯ Yes ◯ No
- My behavioral health *provider(s)*: ◯ Yes ◯ No

Part 4. What health information may be released?

I agree that the entity or entities identified in Part 3 may release the following information (check all that apply):

☐ If I am in treatment	☐ Medical history and physical exam
☐ My prognosis	☐ Psychiatric/Psychological evaluations
☐ Type of program I am in	☐ Physician orders
☐ My progress in treatment	☐ Other:
☐ Incidence(s) of relapse	
Dates of service to release: ______	Dates of service to release: ______

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I understand that if I have identified my physical and behavioral health plans as recipients of my health information, under state law, those entities may only receive the information listed in the left-hand column.

I further understand that no disclosure shall include psychotherapy notes from my behavioral health provider(s).

If the health information I have identified for release above contains HIV-related information, I agree that the entity or entities identified in Part 3 may release that HIV-related information:

○ Yes, I agree ○ No, I do not agree

Part 5. Why is my health information being released?

I agree that my health information identified in Part 4 is being released for the following reason(s):

☐ To allow the entities identified in Parts 2 and 3 to coordinate the health care services and treatment I receive.

☐ Other: ______________________________

Part 6. Signature of Member

- Signing this authorization is voluntary. Your health plans and providers may not withhold treatment, payment, enrollment, or eligibility for benefits based on whether you sign this form.
- This authorization will expire one year from the date that you sign this form.
- Information disclosed by this authorization may be at risk for redisclosure by the program or person that received it. If that happens, it might no longer be protected by federal or state law.
- You have the right to revoke this authorization at any time either in writing or verbally. But if you revoke this authorization, your revocation will not affect any disclosure of information that has already been made by a program or person in reliance on this authorization.
- This authorization only applies to the sharing of your health information regarding substance use.
- If you want to allow your other physical and mental health information to be released, you must also give your separate consent in writing to release that specific information.
- You are entitled to a copy of this authorization in its completed form.

I give my permission to release my substance use information as described in this form.

______________________________ ______________________________

Signature or Mark of Member Date

Part 7. Copy of Consent

☐ Check here if you would like to receive a copy of this consent.

To be completed by staff member upon form completion if signed in a face-to-face meeting:

The Member ☐ Accepted / ☐ Declined to receive a completed copy of this form.

Signature of Staff Member Obtaining Consent: ______________________________

This form has not been formally approved by the Department of Drug and Alcohol Programs ("DDAP") for, and should not be used by, DDAP-licensed providers.

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