Washington State Health Care Authority

Health Home Participation Authorization and Information Sharing Consent

1 Participation Authorization

I, _____ , agree to participate in the Health Home program with _____
Print name of beneficiary — Print name of Health Home Lead

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

2 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 disorder.

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 form takes the place of any other Health Home Participation Authorization and 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 **Health Home Participation-Opt-Out/Decline Services** form and giving it to my Health Home.

PLEASE 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 information about (please put initials next to 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 Substance Use Disorder (SUD) Services** form.

Please initial the appropriate choice below.

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.

_____ _____
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

List your providers/partners on page two.

Print name of Health Home beneficiary

List the name of participating providers/partners	Beneficiary gives consent		Beneficiary withdraws consent	
	Date (MM/DD/YYYY)	Initials	Date (MM/DD/YYYY)	Initials
Past Care Coordination Org. (CCO)/Lead				
Past CCO/Lead				

Annual consent review date (MM/DD/YYYY)	Care coordinator name	Care coordinator signature

This release of information should include page 1 of the *Health Home Participation Authorization and Information Sharing Consent* form in order to provide the legal authority to release information for the beneficiary listed above.

Details about the beneficiary information sharing and consent process:

1. **How will providers/partners use my information?**
   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, 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 coordinator.

3. **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.

4. **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.

5. **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 case coordinator or call the HCA Medical Assistance Customer Service Center (MACSC) toll-free line at 1-800-562-3022 (TRS: 711).

6. **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.

7. **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 Participation - Opt-Out/Decline Services form and giving it to your Care Coordinator. You get this form online or by calling the HCA Medical Assistance Customer Service Center (MACSC) toll-free line at 1-800-562-3022 (TRS: 711). 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.

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