Health Home Participant Information Sharing Consent Form

By signing this form, you agree to be in the _____ Health Home. To be in a Health Home, health care providers and other people involved in your care need to be able to talk to each other about your care and share your health information with each other to give you better care. While being in a Health Home will help make sure you get the care you need, you will still be able to get health care and health insurance even if you do not sign this form or do not want to be in the _____ _____ Health Home.

This form lets the Health Home partners listed at the end of this form to get your health information in order to improve your care. The partners may get your health information including your health records and some prescription drug information. The partners listed on this form may get, see, read, copy, and share ALL of your health information that they need to give you care, manage your care, or study your care to make health care better for participants. The health information they may get, see, read, copy and share may be from before and after the date you sign this form.

Your health records may have information about illnesses or injuries you had or may have had before; test results, like X-rays or blood tests; and the medicines you are now taking or have taken before. Your health records may also have information on:

1. Alcohol or drug use programs which you are in now or were in before as a patient;
2. Family planning services like birth control and abortion;
3. Inherited diseases;
4. HIV/AIDS;
5. Sexually-transmitted diseases and treatment; and
6. Mental health conditions

The partners may give your health information to your other health care providers or other people involved in your care. Your health information is private and cannot be given to other people without your express consent under Maryland and U.S. laws and rules. Some special laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The partners that can get and see your health information must obey all these laws. They cannot share your information unless you agree or the law says they can give the information to other people. This is true if your health information is on a computer system or on paper.

Please read all the information on this form before you sign it.

I AGREE to be in the _____ Health Home and agree that all of the Health Home partners listed at the end of this form may receive my health information through paper or electronic means if they need the information to give or manage my care, check if I am in a health plan and what it covers, to confirm whether I am in a Health Home program, or to study information to improve the care of all patients. I understand this Consent Form takes the place of other Consent Forms I may have previously signed to share my health information, except for my Maryland Medicaid form. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form and giving it to one of the Health Home partners.

DETAILS ABOUT PATIENT INFORMATION AND THE CONSENT PROCESS

1. How will partners use my information?

If you agree, partners will use your health information to:

- Give you health care and manage your care;
- Check if you have health insurance, belong to a Health Home, and what it pays for; and
- Study and improve health care for all participants.

The choice you make does NOT let health insurers see your information so they can decide to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers must use.

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, drugstores, laboratories, health plan companies, the Medicaid program, and other groups that share health information. You can get a list of all the places and people by calling _____or talking to your care manager.

3. What laws and rules cover how my health information can be shared?

These laws and regulations are Health-General Article, Title 4, Subtitle 3, Annotated Code of Maryland; and the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 CFR Parts 160 and 164 and the federal confidentiality regulations 42 CFR Part 2.

4. If I agree, who can get and see my information?

The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for a Health Home partner and who are involved in your health care; health care providers who are working for a Health Home partner who is giving you care; and people who work for a Health Home partner who is giving you care to help them check your health insurance or to study and make health care better for all patients. When you get care from a person who is not your usual doctor or provider, like a new drugstore, new hospital, or other provider, some information, like what your health plan pays for or the name of your Health Home provider may be given to them or seen by them.

5. What if a person uses my information and I didn't 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 the Medicaid Helpline at 1-800-541-2831. 6. How long does my consent last? Your consent will last until the day you take back your consent, or if you leave the Health Home program, or if the Health Home stops operating. 7. What if I change my mind later and want to take back my consent? You can take back your consent at any time by signing a Withdrawal of Consent Form and giving it to one of the Health Home partners. If you agree to share your information, all Health Home partners listed at the end of this form will be able to get your health information. If you do not wish the Health Home partners listed on this form to get your health information, you need to take away your consent from the Health Home program. You can get this form by calling _____. Your care manager will help you fill out this form if you want. Note: Even if you decide later to take back 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. How do I get a copy of this form?

You can have a copy of this form after you sign it.

Participant Name_____
Participant Signature_____ Date_____

Please submit names of Participating Partners on the following page and attach additional pages if necessary.

Name of Participating Partner_____

Name of Participating Partner_____

Name of Participating Partner_____

Name of Participating Partner_____

Name of Participating Partner_____

Name of Participating Partner_____

Name of Participating Partner_____

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