ENHANCED CARE MANAGEMENT (ECM) SERVICES

Authorization for Use, Exchange, and/or Disclosure
of My Confidential Health Care and Personal Information

PURPOSE

Health care providers, health payers, and social services agencies have joined together to provide **Enhanced Care Management (ECM) services** to help promote your health and well-being. To allow Partnership HealthPlan of California ("**Partnership**") and/or other entities to share your health care and other personal information with each other to help provide you with these ECM services, you must give your authorization first. By filling out this form, you are authorizing the use and release of your health care and other personal information by the following entities participating in ECM ("**ECM Entities**"): health care providers such as hospitals, physicians, and pharmacies; Partnership and other managed care plans that administer Medi-Cal benefits and pay for services you receive under Medi-Cal; community-based organizations that must comply with health care privacy laws; school-based providers such as nurses, social workers, and counselors; the California Departments of Health Care Services, Public Health, Social Services, and Developmental Services; and county agencies including, but not limited to, mental health plans; and providers and case managers at correctional facilities, but only for the purposes set forth below. Your authorization will permit ECM Entities to use and release your health care and other personal information for the following purposes ("**Purposes**"): (a) to provide you with, refer you to, or help you receive comprehensive care management services, including coordinating health and health-related care services and case management ("**Services**") to meet your needs; (b) to identify, support, coordinate, improve and arrange payment for Services that may be provided to you; and (c) to help Partnership provide better care through evaluation, reporting, and population health management. The information may be shared in a secure electronic format, in writing, or verbally to coordinate Services for you.

Member Information

First Name:	Last Name:
Address:	
Phone Number:( )	Date of Birth:
Member ID/CIN:	

I authorize and ask that **Partnership HealthPlan of California** and **participating ECM Entities** named in **Attachment A** to use and share any of my health care or other personal information with each other for the purpose stated in this Authorization.

Choose ONE of the following options:

INITIAL HERE	**Consent for communication by ECM Program:** By putting my initials here, I am allowing ALL of the ECM Entities listed in **Attachment A** to use and share my health care and other personal information about my medical history, physical and mental condition, and receipt of social services, and to communicate with each other in order to provide ECM Services. The types of health and other confidential information that I am authorizing to be shared between ECM Entities include: (a) Protected health information ("**PHI**"), including information regarding my health

	care, medical history, lab test results, and current or future conditions and treatment; (b) Mental health information, including current and past diagnoses and treatments of my mental health conditions, excluding psychotherapy notes which are only shared if I sign a separate consent form; (c) Individualized Education Program information and other information about social services provided in school; (d) Medi-Cal eligibility/enrollment information, which includes income and certain other demographic and geographic information pertaining to my eligibility for Services and benefits; (e) Housing/homelessness information, including my housing status, history, and supports; and (f) Limited criminal justice information, including booking data, dates and location of incarceration, and supervision status. My consent does not apply to my criminal history, charges, and immigration status.
INITIAL HERE	**Decline to participate in ECM:** I understand that the ECM program allows ECM Entities to be in contact with each other to coordinate my care. I decline to participate in the ECM program. I can ask to participate in case management programs for which I am eligible.

Further, by putting my initials below, I specifically authorize the release of the following information (this information will NOT be released unless you specifically authorize it)

INITIAL HERE	Mental health information, including diagnosis, treatment plan, and provider name. This does not include psychotherapy notes, which are only shared if I sign a separate consent form.
INITIAL HERE	HIV Test Results (Health & Safety Code § 120980 (g))

Substance Use Disorder Information

Substance use disorder ("**SUD**") records are protected by federal confidentiality rules (42 CFR Part 2). The federal rules do not allow any further release of information that finds a patient as having or having had a substance use disorder either by reference to publicly available information, or through proof of such identification by another person unless further release is permitted by the written consent of the person whose information is being given or as otherwise permitted by 42 CFR Part 2. The federal rules restrict any use of the information to investigate or prosecute, with regard to a crime, any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. By filling out this section, you are authorizing ECM Entities to use and release the following SUD information for the Purposes described in this form: your current and past drug or alcohol use diagnoses, medications, treatment, lab tests, trauma history, facility discharges, and any other SUD information about you that comes from a substance/alcohol use disorder provider subject to federal SUD confidentiality regulations (42 C.F.R. Part 2). SUD records (or information therein) that are used or disclosed for treatment, payment, or health care operations by certain ECM Entities, including health care providers, health plans and other third-party payors, may be redisclosed as permitted in the federal HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you. Your SUD counseling notes will not be shared unless you sign a separate consent form.

INITIAL HERE	Initial here to allow the ECM Entities in **Attachment A** to use and share your SUD information as described above, excluding SUD counseling notes.

Expiration of Form

Choose ONE of the following two options:

INITIAL HERE	**Standard expiration:** This authorization will expire 1 year from today's date; OR
INITIAL HERE	**Expiration:** This authorization will expire on:_____. This date may not be less than 6 months (to participate in the ECM program), but may be more than 1 year from today's date.

I understand that:

- I can revoke this Authorization at any time by calling Partnership at (800) 863-4115 or by sending a signed revocation request to:

  Partnership HealthPlan of California
  Attn: Enhanced Health Services
  4665 Business Center Drive
  Fairfield, CA 94534
- A revocation is effective when received, but may not apply to information already shared, based on my prior consent to use or release information.
- I can choose to not sign this form and doing so will not affect my treatment or care, my eligibility for or ability to receive Services, or the payment for Services. However, my ability to participate in the ECM program may be affected by not signing this Authorization.
- Even if I do not sign this form, under federal and state privacy laws, some of the ECM Entities may share my confidential information for treatment, payment, and other purposes, but providers subject to federal substance use confidentiality laws generally may not share my substance use disorder information without my consent (42 CFR Part 2).
- The information I authorize for use or release may be re-shared by ECM Entities, but only in compliance with this Authorization and applicable law.
- I can get a copy of the health information that is being shared.
- I have the right to ask for a copy of this form and one will be sent to me.
- I may obtain a list of all ECM Entities to which my information has been disclosed, including those entities identified in **Attachment A**, by contacting Partnership.
- If I voluntarily include my phone number above, I consent to the receipt of texts or calls to communicate with me about my consent choices and how my health and other confidential information may be shared (standard message and data rates may apply).
- Each of the above rights extend to any representative I authorize under applicable law.

[*signature on next page*]

Signature of Member

If you are signing this Authorization on your own behalf, fill out the first line. If you are signing on behalf of someone else, fill out the second line. If you are signing on behalf of a minor aged 12-17, the minor should fill out the first line and you should fill out the second line.

Beneficiary's Name	Beneficiary's Signature	Date (mm/dd/yyyy)
Representative's Name	Representative's Signature	Date (mm/dd/yyyy)