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 services under the **ECM benefit** to help you get the services you may need to promote your health and well-being. To allow Partnership HealthPlan of California (PHC), and/or other participating entities to share your health care and other personal information with each other, you must first give your authorization (permission). By completing this form, you are authorizing the use and disclosure (release) of your health care and other personal information by the entities participating in ECM. The participating entities will only use and share the information necessary to achieve the intended purpose or referral. The information may be shared in a secure electronic format, in writing, or verbally during meetings to coordinate services for you. Please complete this form and send it to:

Partnership HealthPlan of California
Attn: Care Coordination – Northern Region
3688 Avtech Pkwy
Redding, CA 96002
Fax: (530) 351 -9040

OR

Partnership HealthPlan of California
Attn: Care Coordination – Southern Region
4665 Business Center Drive
Fairfield, CA 94534
Fax: (530) 351-9040

Member Information

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

I authorize and request (ask) **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 above.

Choose ONE of the following two options:

INITIAL HERE	**Consent for communication by ECM Program:** By initialing here, I am allowing ALL of the agencies listed in ATTACHMENT A to use and share my health care and other personal information pertaining to my medical history, physical condition, and receipt of social services, and to communicate with each other in order to provide ECM services, OR
INITIAL HERE	**Decline to participate in ECM:** I understand that the ECM program permits community partners to communicate with each other to coordinate my care. I decline to participate in the ECM program. I can ask for participation in case management programs that I am eligible for.

Further, by initialing below, I specifically authorize 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.
INITIAL HERE	HIV Test Results (Health & Safety Code § 120980 (g))

Substance Use Disorder Information

Substance use records are protected by federal confidentiality rules (42 CFR Part 2). The federal rules do not let any further disclosure of information that identifies a patient as having or having had a substance use disorder either by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 acrime, any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

INITIAL HERE	Initial here to allow the entities in Attachment A to use and share ALL of your drug and alcohol information, including test results, treatment plans, programs attendance, communication with counselor and diagnosis.

Expiration and Revocation

Choose ONE of the following two options:

INITIAL HERE	**Standard expiration:** This authorization will expire exactly 5 years from today's date, OR
INITIAL HERE	**Early expiration:** This authorization will expire on:_____. This date may not be less than 6 months (to participate in the ECM program), nor more than 5 years from today's date.

This authorization may be withdrawn and revoked (taken back) at any time by calling PHC at (800) 863-4155 or by sending your signed request to: Partnership HealthPlan of California, Attn: Member Services 4665 Business Center Drrive, Fairfield, CA 94534. The revocation will take effect when PHC receives it, but does not affect information that has already been disclosed.

Signature of Member

I understand that:

- I may refuse to sign this authorization. My refusal could affect my ability to participate in theECM program. My refusal will not affect my ability to get treatment, services, or eligibility for benefits otherwise available to me.
- Some information shared under this Authorization may be re-shared with others under certainconditions and may no longer be protected by State and Federal confidentiality laws.
- 42 CFR part 2 does not allow re-disclosure of substance use records that are subject to that partwithout my authorization.
- I may inspect or get a copy of the health information that is being shared.
- I have a right to ask for a copy of this authorization and one will be sent to me.

Signature	Date
Printed Name	Relationship to Member