



Member/Recipient Name: _____

Date of Birth: _____

Record Number: _____

Release of Information Form for Treatment, Payment, Health Care Operations (TPO)

Part 2 Notice to Recipients of Part 2 Records

If substance use information has been included, this record which has been disclosed to you is protected by Federal confidentiality (privacy) rules ([42 CFR part 2](#)). These rules prohibit you from using or disclosing this record, or testimony that describes the information in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at [42 CFR 2.12\(c\)\(5\)](#) or as authorized by a court in accordance with [42 CFR 2.64](#) or [2.65](#). The Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies:

- i. Further use or disclosure is expressly allowed by the written consent of the individual whose information is being disclosed in this record or as otherwise allowed by [42 CFR part 2](#).
- ii. You are a covered entity or business associate and have been sent the record for treatment, payment, or health care operations, or
- iii. You have been sent the record from a covered entity or business associate as allowed by [45 CFR part 164, subparts A and E](#).

A general consent for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see [42 CFR 2.31](#)).



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Instructions for use

These instructions will help you fill out the **Alliance Release of Information form for Treatment, Payment, Healthcare Operations (TPO)**. Please read this form carefully and make sure you fully understand all the information before signing.

- By signing this form, you give Alliance Health authorization (consent or permission) to share your medical, billing, and administrative records (also known as your Designated Record Set under HIPAA).
- If you have any questions or trouble filling out the form, contact the Medical Records department at medicalrecords@alliancehealthplan.org or your care worker.
- The Part 2 Notice lets the recipient know how they can use or further disclose the Part 2 (substance use) records based on the Federal confidentiality rules 42 C.F.R. Part 2.
- **NOTE: We are not allowed to combine a substance use TPO release form with a release to share information for any type of legal purposes.**
- Please make sure at the top of the form on each page, the Member or Recipient first and last name and date of birth are added. Employees can add the ACS record number if known. If the record number is not known, leave blank.

Below are explanations of each section of the Release of Information form:

1. **Authorized Recipients (required)** - This is where you will add who you want Alliance to share your medical, billing and administrative records with. You can **pick one** of two options: The choices are
 - a. All my treating providers, health plans, third party payers, and people helping to operate Alliance,**OR**
 - b. You can list the recipients. They must be providers, health plans/third party payers or other people who help Alliance run their business. If you wish to share your records with someone other than one of these agencies, please complete the Alliance Release of Information form for non-Covered Entities.
2. **Information to Be Released (required)**- Alliance will share either your entire record which includes your billing record, your entire billing record or specific documents. If “All My Health Information” is chosen, health information includes, but is not limited to, all records and other information about your health history, treatment, hospital visits, tests, and outpatient care. “All My Health Information” may also include information about sensitive conditions:
 - Mental health records
 - Drug, alcohol, or substance abuse records
 - Records or tests relating to HIV/AIDS
 - Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502)

If you choose specific documents to disclose, these may include:

- | | |
|--|------------------------|
| • Care Coordination information (assessments, notes) | • Labs and medications |
| • Plans including Service, Treatment, Person Centered, or Individual | • Evaluations |
| • Admission and Discharge Assessments and Summaries | • Authorizations |
| • Histories and Physicals | • Radiology reports |

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3. **Why would I share my protected health information (Purpose)?** This section explains the goal of sharing protected health information (PHI) and when it is needed. For purposes of this release, your records will be shared for these reasons:
- TPO
 - Treatment- to coordinate your care, referral for services, discharge planning
 - Payment- to pay for your care, receive approvals for your treatment, verifying your coverage
 - Operations- Evaluating our providers, performing audits
 - At Your Request- Because you are telling us to share your records
 - If there is another purpose related to TPO, you can list it here
4. **Do I have to pay to share my records?** This section explains that there may be a fee to get copies of medical records.
- For Alliance Staff – if you have questions about fees, please refer to our Fees for Reproduction of Records procedure located on the Grid.
 - For Members, Recipients and LRPs – to get a copy of our fees, send an email to medicalrecords@alliancehealthplan.org or call 919-678-5407 or 877-524-0011.
5. **Format- How do you want your records to be shared?** Check the box to tell us how the records should be sent to the Recipient(s) listed on the Release. If a box is not checked, records will be mailed to the address on file with Alliance.
6. **Notice of Voluntariness- Do I have to sign this form and share my information?** This section explains that you do not have to sign this form or share your information if you do not want to.
7. **Can I get a copy of this form?** When Alliance (or other agency) asks a person to sign this form, a copy must be sent to the person who signs it. If the release form is signed while out in the community, a copy may be mailed or e-mailed. A copy of this form will also be mailed when records are disclosed based on this release.
8. **Redisclosures and Confidentiality- Can the person who receives my information share it with others?** This section explains the laws protecting the information Alliance has shared and the requirements the Recipient(s) must follow before they can legally share the information. In most cases, a release of information is required unless there is an exception to the law.
9. **Revocation- What if I change my mind?** The Member, Recipient or LRP has the right to take back (revoke) their authorization at any time.
10. **Expiration (required)-** This section explains that the release will automatically expire on the date, an event or a condition that is listed on this form chosen by you.
11. **Signatures (Required)** - Minor signature is required if substance use disorder (SUD) information is being shared.
12. If the Member or Recipient has a guardian, they are required to share their relationship to the Member or Recipient. If there is a guardian, Alliance is required to have a copy of the legal documentation appointing the guardian.



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Release of Information Form for Treatment, Payment, Healthcare Operations (TPO)

I authorize **Alliance Health** to disclose my protected health information (PHI) to the following:

AUTHORIZED RECIPIENT(S) my PHI can be shared with (**Pick One**):

☐ All my treating providers, health plans, third party payers, and people helping to operate Alliance.

OR

☐ Specific Recipient(s)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Information may be shared through *verbal, electronic, or written* communication. Release of information means that Alliance Health and the authorized recipient(s) listed above can communicate with each other and share information back and forth.

Health information shared will contain information from third parties including health care providers. Records released *may* include the following types of information:

- Behavioral Health •Communicable (Infectious) Disease •Genetic Testing •Physical Health •Pharmacy
- Reproductive and Maternity •Substance Use •Vision

Information to be released

I authorize the following information to be disclosed (shared):

☐ All My Health Information

☐ All My Billing Records

OR

☐ I authorize only the disclosure (sharing) of the following information (what records do you want shared):

I understand the purposes for the disclosure/redisclosure authorized by this form are:

☐ For my treatment, payment for treatment, and health care operations

☐ At my request

☐ For the purpose of: _____

Fees- Do I have to pay to get a copy or share my records?

Alliance Health may charge a reasonable fee for copies of your medical or administrative records. For a cost estimate, you can email medicalrecords@alliancehealthplan.org or calling 919-678-5407 or 877-524-0011.



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Format Requested / Delivery Method- I would like for Alliance Health to share my information to the Recipient/s listed above in the following format. Please note that this selection only applies to the disclosure of records based on this release.

- ☐ Mail paper records to this address: _____
- ☐ Review or pick up paper records at this Alliance office: _____
- ☐ Receive electronically via email (check one and print email address)
- ☐ Unsecure/unencrypted* ☐ Secure/encrypted (may be size limitations)
- Email address: _____
- ☐ Other: (describe) _____

***Please note:** Sending PHI by unencrypted email is not secure. This means unauthorized parties may be able to see your information without permission. If not checked, information will be sent encrypted.

Notice of Voluntariness – Do I have to sign this form and share my information?

You do not have to sign this form. If you choose not to sign this form, Alliance Health cannot refuse payment for treatment, enrollment in a health plan, or eligibility for health plan benefits.

Can I get a copy of this form?

If you fill out and sign this form, a copy of the signed release form will be given to you. If you sign this form you may also review or copy the health information shared as allowed by N.C.G.S. § 122C-53(c).

Redisclosure and Confidentiality - Can the person who receives my information share it with others?

My signature below shows that I understand:

- What information will be released and the need for the information.
- Once information is disclosed, the federal privacy law (45 CFR Part 164) protecting health information may not apply to the person who is sent the information, and this may not stop them from sharing my information with others. Other laws, however, may prohibit redisclosure.
- Mental health and substance use treatment information has more protection.
- My alcohol and/or drug treatment records are protected by federal law (42 C.F.R. Part 2).
- My mental health, developmental disabilities, and substance use disorder treatment information is protected by state law (G.S. 122C).
- If I authorize the disclosure (sharing) of information protected by these two laws, these two laws still protect my information, and those who receive this information may not share it with anyone else except as allowed under these laws or this form. Our Notice of Privacy Practices describes when and how disclosure is permitted or required by these laws.
- If HIPAA covered entities and business associates receive substance use records for treatment, payment, and health care operations purposes, the records may be redisclosed in accordance with HIPAA, except for uses or disclosures for civil, criminal, administrative, or legislative proceedings against me.
- Records may be used or disclosed as listed in this consent and may be subject to redisclosure by the recipient and no longer protected by the Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2).



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Revocation and Expiration - What if I change my mind?

I understand that I have the right to revoke (take back) this authorization at any time. I also understand that if I revoke this consent, it will not change the sharing of information that has already happened.

If not revoked sooner, this consent will expire on the date, event or condition listed here **(required)**:

_____.

If you choose to revoke this consent, you may contact the employee working with you or the Privacy Officer as outlined in the Notice of Privacy Practices.

If you agree to let Alliance Health share your information as outlined above, please sign and date below.

Minor Signature (required for SUD)

Date

*Signature of member/recipient/legally responsible person
(LRP)*

*Relationship (Required
for LRP)*

Date