Consent to Share Confidential Health Information

This form is required when a member is transferring from one health plan to another, and the member has a substance use disorder (SUD) diagnosis or is receiving treatment for a substance use disorder. Please return completed forms to roi@AllianceHealthPlan.org. Alliance will not be able to share or transfer member SUD information to the new health plan without a signed release form.

Member information

1

Name of member _____

Member's date of birth (mm/dd/yyyy) _____

Clinician/provider representative _____

An explanation of this form

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You will soon have a different health plan to manage your Medicaid healthcare benefits. We need your consent to share records about your treatment with your new health plan. Your consent will help ensure your new health plan has the information it needs to continue to provide access to and payment for your health care, you can take back your consent any time you want by signing the revocation section on this form and giving it to Alliance Health Medical Records via e-mail: medicalrecords@AllianceHealthPlan.org; Fax 919-651-8651; or mail to 5200 West Paramount Parkway Suite 200 Morrisville, NC 27560. You can tell us how long you want this consent to be valid, or you can tell us an event or condition upon which it will expire. If you don't give us a different time frame your consent is good for one year. You will be given a copy of this form to keep.

Giving your permission to share your records

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To ensure that my current services are not interrupted and that my new health plan can support me effectively, I _____ (name of member/patient or legally responsible person) hereby authorize Alliance Health to transfer and share information related to my prior authorizations, treatment received and care plans with:

Name of Prepaid Health Plan ("PHP")	Initials next to applicable PHP. If member does not know PHP, provider may reflect PHP assignment with X and secure member's initial to confirm consent.
AmeriHealth Caritas	
Carolina Complete Health	

Giving your permission to share your records

Continued

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Name of Prepaid Health Plan (“PHP”)	Initials next to applicable PHP. If member does not know PHP, provider may reflect PHP assignment with X and secure member’s initial to confirm consent.
Healthy Blue	
United Healthcare	
WellCare	
Alliance Health	
Partners	
Trillium	
Vaya Health	
Local health department (please specify) _____	

Giving your permission to share your records

Continued

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By signing this form, I authorize Alliance Health to share the following specific information with the health plan identified above, which may include information relating to my substance use disorder diagnosis, condition and treatment:

1. My name, address, and other personal identifying information, including social security and Medicaid Identification number
2. Substance use treatment information, including diagnosis, treatment, services, person centered plans, utilization review information, prior authorizations for services, and care plans
3. Substance use treatment progress and compliance reports
4. Medications and reason for prescription
5. Reportable communicable disease information, including HIV/AIDS, sexually transmitted infections, hepatitis, and tuberculosis
6. Financial information, including health plan or health benefits information
7. Other (specify, if any)

Revocation and expiration

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I understand that I have the right to end this authorization at any time, except to the extent that a person or agency that is permitted to make a disclosure has already taken action in reliance on it. If not revoked sooner, or by the date, event, or condition set out below, this authorization expires automatically one year from the date it is signed or upon my disenrollment from the NC Medicaid Program.

Voluntariness

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I understand that I have the legal right to refuse to sign this authorization form. If I choose not to sign this form, I understand that healthcare providers and health plans cannot deny or refuse to provide treatment, payment for treatment, enrollment in a health plan, or eligibility for health plan benefits because of my refusal to sign.

Redisclosure and confidentiality

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My signature below indicates that I understand what information will be released and the need for the information to be released to my new health plan. I further understand that the information to be released may include information regarding my substance use disorder diagnosis, condition or treatment or HIV infection, AIDS, or AIDS related conditions. Information relating to HIV infection, AIDS or AIDS related conditions shall be released only in accordance with N.C.G.S. §130A-143. In addition, information related to my substance use disorder diagnosis, condition or treatment in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 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). Once information is disclosed pursuant to the signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. I understand that when you disclose my mental health, intellectual and developmental disabilities information protected by state law (N.C.G.S. §122C-52) or substance use disorder diagnosis, condition or treatment information protected by federal law (42 CFR Part 2), you must inform the recipient that redisclosure is prohibited except as permitted or required by these two laws.

Signature of member under age 18 (if required for substance use disorder information)		Date (mm/dd/yyyy)
x		

Signature of member		Date (mm/dd/yyyy)
x		

Signature of legally responsible person		Date (mm/dd/yyyy)
x		

Full name of legally responsible person

Relationship of legally responsible person

Revocation section

(Please complete only if you are revoking consent)

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I revoke this authorization to disclose confidential health information of _____, signed by _____ on _____. This revocation is effective on _____. I understand that actions taken based upon this authorization prior to this revocation date are legal and binding.

Signature of member	Date (mm/dd/yyyy)
x	

Signature of legally responsible person	Date (mm/dd/yyyy)
x	

Full name of legally responsible person

_____

Relationship of legally responsible person

_____

NOTICE OF PROHIBITION ON RE-DISCLOSURE OF PART 2 RECORDS

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This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). 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.