CONSENT TO THE DISCLOSURE OF SUPPORTING DOCUMENTATION FORM.
PERMISSION TO USE AND DISCLOSE CONFIDENTIAL HEALTH INFORMATION FOR THE USE OF CARE COORDINATION ASSIGNMENT

By signing this Consent Form, you permit parties completing a referral on your behalf to share your health information so that your Health Home can have a complete picture of your health and help connect you to better care. Your health records provide information to determine your eligibility for the Health Home program. Your health records provide information about your illnesses, injuries, diagnoses, medication and/or test results. Your records may include sensitive information.

If you permit disclosure, your health information will be used to assist in Care Coordination related to your health and social service's needs. Your health information may be re-disclosed only as permitted by state and federal laws and regulations These laws limit re-disclosure of information about your treatment at a substance use or mental health program, HIV related information, genetic records, and records of sexually transmitted illnesses.

Your choice to give or deny consent to disclose your health information to the SMH Health Home Program will not be the basis for denial of health services or health insurance. Your choice to give or deny consent is solely for the purpose of obtaining supporting documentation to determine eligibility for the Health Home Program. If you choose not to consent into the Health Home program after a referral has been submitted on your behalf, the Health Home Program is not required to return this information or remove it from their records. You are entitled to a copy of this consent form after you sign it.

CONSENT TO THE DISCLOSURE OF SUPPORTING DOCUMENTATION

1. The person whose information may be used or disclosed is:

2. Name: _____ Date of Birth: _____

3. The information included in the supporting documentation that will be disclosed to the Health Home Program is for the purpose of determining eligibility for Health Home services and ongoing care coordination. The information that will be disclosed includes records of diagnosis and health care treatment, which could include but not limited to, Mental Health records, Substance Use Treatment records, HIV related information, Genetic information, and information about sexually transmitted diseases.

4. Use and disclosure of this information is permitted only as necessary for the purposes of Care Coordination Services including outreach, referrals, individualized care planning and monitoring of the quality of service.

5. I understand that I can choose not to pursue Care Coordination services at any time. I also understand that records disclosed with this “Consent to the Disclosure of Supporting Documentation” may not be retrieved. Any person or organization that relied on the supporting documentation may continue to use or disclose that information as needed to complete services.

I authorize the use and disclose of my personal information as described in this document and consent to the referral to the St. Mary’s Healthcare Health Home Program.

Signature of Individual/Parent/
Guardian/Legally Authorized Representative: Date:

Relationship to Referred Member:
