Authorization for NHP to Release Confidential Information

I, _____ **(Member Name)** authorize Northeast Health Partners (or any NHP partners, vendors, or health care providers who engage in electronic transactions) to disclose my health care information as described below.

Member Medicaid ID#: _____**DOB:**_____**Phone number:**_____

This authorization shall be in force and effect **for one year** or until I revoke it, as described below or until **(insert expiration date or event)**_____ *(whichever is shorter)*.

My information will be shared for the following purpose(s) (check all that apply):

☐ Care coordination/case management/referral to treatment
- Community Mental Health Center (name)_____
- Primary Care Doctor/clinic/hospital (name)_____
- Dentist (please name)_____
- Department of Human Services (name)_____
- School (please name)_____
- Housing Assistance (name)_____
- Food Assistance (name)_____
- Transportation (name) _____
- SSDI/Aid to the Needy & Disabled {AND} (name) _____
- Treatment Facility (name) _____

☐ Payment of treatment services

☐ Health Care Operations to include:
- To explain benefits and coverage
- Prior authorizations, billing, and claims
- Grievance and/or appeal representation
- Research
- Audits and evaluations

☐ Legal representation
- Judicial (probation/parole) (name) _____

☐ Other _____

By checking one of the boxes below, I give my permission to share the following information:

☐ All behavioral health and substance use treatment records according to 42 CFR Part 2. You may read more about your rights under this rule at www.samhsa.gov. **OR**

Only limited information may be shared (put a check by the information you would like shared).
____ Billing and claims information/prior authorizations
____ Medicaid eligibility information
____ Assessments/case management notes/treatment plans
____ Demographic information
____ Other (please specify) _____

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Specific health information will not be shared, unless I select below:

_____ HIV/AIDS related information and/or records
_____ Genetic testing information
_____ Drug and/or alcohol diagnosis, treatment, and referral information

Authorization Statements

I am voluntarily signing this authorization. I understand that I may refuse to sign this authorization. If I refuse to sign this authorization, my health care benefits or payment for my healthcare benefits will not be affected.

- I may cancel this authorization at any time. To cancel this authorization, I may call Northeast Health Partners at (800) 541-6870; State Relay: 711 or send an email to: nhpmembersupport@nhpllc.org.
- I understand that if I cancel this authorization, it will not affect information that was shared before Northeast Health Partners received my **written cancellation**.
- If you have authorized the release of substance use treatment records **ONLY**, you may verbally cancel this authorization.
- I understand that if I give permission to share my information, the people or organizations who receive my information may not be required to protect my information.
- I understand I can request a copy of this form and to request a copy of the information that is disclosed.
- Preferred methods of contact:
    - I agree to be contacted by:
        - Home Phone: _____
        - Cell Phone: _____
        - Email: _____
        - US Mail Address: _____

_____ _____
Signature of the member or personal representative Date

_____ _____
Name of the member's personal representative Date

Personal Representatives: If you are signing this authorization, you must include documentation that supports your authority to make health care decisions on behalf of the member.

Minors: Minors 12 years and older may authorize the release of mental health information by signing this form. Minors of any age may authorize the release of health care information related to the treatment of sexually transmitted diseases, including HIV/AIDS, alcohol and/or drug abuse treatment, contraception treatment, and prenatal care services. You may read more about House Bill HB19-1120 at www.colorado.gov.

Please send the completed form to P.O. Box 31364 Salt Lake City UT 84131-0364. You may also Email the form to nhprae2.org.