Release of Information

Authorization to Use or Disclose Protected Health and Confidential Information

I, _____, on behalf of _____ (self/minor child), give my permission to NHP, to release and request specific protected health information (PHI) about me/my minor child for the purposes of (check all that apply):

- ☐ Care Coordination
- ☐ Enhanced Standardized Assessment
- ☐ Residential treatment request
- ☐ Care Team Meetings (including Creative/Complex Solutions, care consultations)
- ☐ Quality of care grievance
- ☐ Other: _____

Information for the Member about which PHI is to be shared:

Member name: _____ Date of birth: _____

Medicaid ID: _____ Home address: _____

Parent/guardian/responsible party (if applicable): _____

Phone number: _____ Email: _____

Information to be released or requested:

- ☐ I consent to the disclosure of ALL the information listed below **OR**
- ☐ Limit the disclosure of information to the following (check boxes):
  - ☐ Care coordination notes, incl. care team meetings
  - ☐ Enhanced Standardized Assessment summary
  - ☐ Medicaid eligibility information
  - ☐ Demographic information
  - ☐ Drug/alcohol use information
  - ☐ Diagnoses
  - ☐ Evaluation/assessment (other than ESA)
  - ☐ Educational records
  - ☐ Legal history and documentation
  - ☐ Custody and guardianship information
  - ☐ Genetic testing information
  - ☐ Complete medical, mental health, and/or substance use disorder treatment records, **OR select specific components**:
    - ☐ Billing and claims information

- ☐ Mental health treatment plan
- ☐ HIV/AIDS related information/records
- ☐ Mental health treatment summary
- ☐ Substance use disorder treatment plan
- ☐ Substance use disorder treatment summary
- ☐ Progress notes, verbal or written
- ☐ Emergency department/acute care records
- ☐ Primary care records
- ☐ Specialty care records

I consent for the above specified information to be released and/or obtained from the following:

Name of Organization/Person(s)	Relation to Member	Phone Number	Email Address

Authorization and Signature(s):

This authorization expires (select one)

- ☐ Two years from the signature date
- ☐ On this specific date or upon this event: _____

I understand that my records are protected under federal regulations, including HIPAA and 42 C.F.R. Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder (SUD) records maintained by NHP that pertain to me. I understand that SUD records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. If I consented to the sharing of information about HIV/AIDS, I understand that it may be contained in records released to the above-named person(s)/organization(s).

I understand that I may revoke this approval at any time. I understand that I cannot cancel this approval when this form has already been used to disclose information. I also understand that the recipient(s) of protected health information may in some circumstances share it and the information may then no longer be protected by HIPAA. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that my revocation must be in writing.

I understand that NHP and its administrative services organization, Rocky Mountain Health Plans, will release information to third party payer sources for the sole purpose of billing for my treatment. This disclosure will be used for the purposes of Treatment, Payment, and Operations. As such, NHP may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this Authorization.

I understand I am entitled to and can request a copy of this Authorization if one is not offered to me.

_____
Name of Member

_____
Name of Parent/Legal Guardian/Responsible Party (if applicable)

_____ _____
Signature of Member/Parent/Guardian Date

_____ _____
Signature of Member/Parent/Guardian Date

If signed by the Member's personal representative, select the legal authority of the representative to act on behalf of the individual. NHP reserves the right to request legal documentation that demonstrates this authority:

- ☐ Parent/legal guardian
- ☐ Court Appointed Guardian/Health Care Agent
- ☐ Medical Power of Attorney
- ☐ Other: _____