



DRAFT

Health Home Consent
Information Sharing (Form B)
For Use with Children and Adolescents Under 18 Years of Age

Instructions for Care Manager: This form must be used for children and adolescents less than 18 years of age who have been enrolled in a Health Home using Form A*. This form outlines what, and with whom, health information can be shared. Section 1 of this form should be completed by the child/adolescent's parent, guardian, or legally authorized representative. Section 2 of this form is completed separately by the child or adolescent with the care manager. Legally authorized representative for the purpose of sharing health information is defined as "a person or agency authorized by state, tribal, military or other applicable law, court order or consent to act on behalf of a person for the release of medical information".

*[Please note, children and adolescents who are parents, pregnant, and/or married should not use this form to consent for health information sharing. Rather, they must use the *Health Home Patient Information Sharing Consent* form (DOH 5055)].

Name of Health Home

Name of Child/Patient/Client

Date of Birth

Information Sharing

1. How will the Health Home and its partners use the child's health information?

If you agree, the Health Home and its partners will use the child's health information to:

- Help the child get care and manage his or her care
- Check to make sure the child's health insurance is working and what it pays for

Health insurers cannot use this health information to decide if they will give the child health insurance. They cannot use this health information to decide what services they will and will not pay for. The health insurers have their own forms to make decisions about their members.

2. Where does the child's health information come from?

The child's health information comes from places and people that gave the child health care or health insurance in the past. These may include hospitals, doctors, pharmacies, laboratories, health plans (insurance companies), the Medicaid program, dentists, and other groups that share health information. You and the child can get a list of all the places and people by talking to the child's care manager.

3. What laws and rules cover how the child's health information can be shared?

These laws and regulations include New York Mental Hygiene Law Section 33.13 and 33.16, New York Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (which are the rules referred to as the Health Information Portability and Accountability Act (HIPAA)).

4. If I agree, who can share the child's health information?

You will decide who shares the child's health information.



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In some situations, the law lets the child decide who can share his or her health information. Here are some situations where the child has control over his or her health information and who gets to share it:

- Family planning
- Emergency contraception
- Abortion
- Sexually Transmitted Infection Testing and Treatment
- HIV testing
- Prenatal Care, Labor/Delivery
- Drug and Alcohol Treatment
- Sexual Assault Services
- Mental Health Services - if you are over the age of twelve, your clinician may ask you before releasing information

New York State also has access to the child's health information because it pays for the child's Medicaid services. New York State may use the child's health information to learn more about the Health Home program to make changes and improve it.

5. What if a person uses the child's health information and neither I nor the child agreed to let them use it?

If you or the child think a person used the child's health information and neither you nor the child agreed to give that person the child's health information (other than the situations mentioned in question 4 when the child has control over their health information), you can:

- call one of the partners you have said can see the child's records,
- call _____ at _____,
- call the Office of Civil Rights at 1-800-368-1019, or
- submit a written complaint at: <http://www.hhs.gov/ocr/civilrights/complaints/>

6. How do I get a copy of this form?

You will get a copy of this form after you sign it. You or the child can also ask for a copy from the child's Care Manager _____ at (phone number) _____.

Participating Partners

Section 1:

Instructions for Parent/Guardian/Legally Authorized Representative: Please list all of the child's health providers who can share the child's health information. These providers can share this information with each other and with the child's care manager/care management team below. The child can keep private any information about birth control, abortion, sexually transmitted infection testing and treatment, HIV testing, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services. Providers of these services will be listed in Section 2.

Instructions for Care Manager: This section is completed by the child's parent, guardian, or legally authorized representative. It is a list of all health providers who can share the child's health information. These providers can share all health information **except** for any information about birth control, abortion, sexually transmitted infection testing and treatment, HIV testing, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services. Copy this page as needed to be able to list all agreed to partners. If this list needs to be updated in the future (to either add or remove a name), please have the parent/guardian/legally authorized representative initial and date next to each new entry or omission.

Instructions for Participating Provider: If your name or agency is listed in Section 1, you may release the child's health information **except** for any information about birth control, abortion, sexually transmitted infection testing and treatment, HIV testing, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services. You may only release this information if you are given permission to do so in Sections 2 of this form.

Parent/Guardian/Legally Authorized Representative Initials

Date

Name of Participating Partner/Provider



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Name of Participating Partner/Provider

By signing this form, I agree that:

1. The child listed above is enrolled in the Health Home listed above,
2. I have signed a consent for enrollment form with the Health Home indicated above for the child listed above,
3. I have had the chance to review the Information Sharing section above and have had my questions answered, and
4. The Health Home and anyone I have named in Section 1 of this form can share (Name of Child/Patient/Client) health information.

I can change this form at any time. I can fill out a new form, add new information, or cross out information. This consent will stay in place until I withdraw it or until the child is no longer eligible for a Health Home. I can always take back this consent on behalf of the child by signing a Withdrawal of Consent Form. **If I do not sign this consent form, I understand that the child will not be enrolled in the health home.**

Print Name of Child's Parent, Guardian or Legally Authorized Representative

Relationship of Legally Authorized Representative to Child (If Applicable)

Signature of Child's Parent, Guardian or Legally Authorized Representative

Date



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*****TO BE COMPLETED WITH MINOR ONLY*****

Section 2:

Instructions for Care Manager: Section 2 of this form should be completed by the child, patient, or client. Completion of this form should be done in private, without the child’s parent, guardian, or legally authorized representative, to ensure confidentiality of the information. Section 2 of this form should be completed after Section 1 has been completed and signed by all necessary parties.

I, **(Name of Child/Patient/Client)**, understand that I can consent for certain types of health care services without my parent, guardian, or legally authorized representative knowing. I can also decide who is allowed to share information about these services. For the services below (which I may have had in the past) I am initialing to give the following Participating Partner/Provider permission to share information regarding that care. I can specify exactly what I would like shared.

Types of Services and Name(s) of Provider and/or Agency Providing these Services	It is okay to share information about these services with my parent, guardian or legally authorized representative named below			It is okay to share information about these services with the Health Home participating partner/providers named above in Section 1. If No is selected, it is okay to share information about these services only with the providers named below.		
	Y	N	Name	Y	N	Name
Family Planning Provider(s): _____						
Emergency Contraception Provider(s): _____						
Abortion Provider(s): _____						
Sexually Transmitted Infection Testing and Treatment Provider(s): _____						
HIV Testing Provider(s): _____						
Prenatal Care, Labor/Delivery Provider(s): _____						
Chemical Dependency Provider(s): _____						
Drug and Alcohol Treatment Provider(s): _____						
Sexual Assault Services						



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Provider(s): _____					
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List here what specific type of information (indicated above) that you would like to share with:

Your parent, guardian, or legally authorized representative:

Participating Health Home partner or other provider:

Other (list) _____:

I AGREE that the Health Home and any people I have listed in Section 2 can share my health information. I can change my mind at any time. I can fill out a new form, add new information, or cross out information. This consent stays in place until I withdraw it or until I am no longer eligible for a Health Home. I can take back this consent at any time by signing a Withdrawal of Consent Form.

Print Name of Child/Patient/Client

Child's Date of Birth

Signature of Child/Patient./Client

Date