Washington State Health Care Authority

Washington State Department of Social & Health Services
Transforming lives

Health Home — Adolescent Information-Sharing Consent

You have been enrolled into Health Homes. Your health care providers and others involved in your care need to be able to talk to each other about your health needs and care. At times, your health records may include information about:

- Family planning services, such as birth control and abortion
- HIV/AIDS
- Sexually transmitted diseases (diseases you can get from having sex)
- Mental health medications and services
- Chemical dependency services

Since this type of health information is private, the health care providers and others who have your health information cannot give it to anyone unless you agree or the law allows it. This is true whether your health information is on a computer system or on paper.

By signing this consent, you are agreeing that the people you have identified on this form have permission to view your private confidential medical information and may consult with one another to help you manage your health care. This health information may be from before or after the date you sign this form. Your health records may have information about illnesses or injuries you have or may have had before; test results, such as x-rays or blood tests; and the medicines you are taking now or have taken before.

If you are age 13 years and older and have been referred to Health Homes, you will be asked to sign this form, whether or not this type of health information applies to you. If you do not sign this form, you will still be able to get Health Home services.

The laws that apply to these health records include:

- Sexually transmitted diseases: Revised Code of Washington (RCW) 70.24.105
- Mental health records: Revised Code of Washington (RCW) 71.05.620
- Chemical dependency: 42 Code of Federal Regulations (CFR) Part 2

I agree to allow Health Homes to receive and share my health information with the health care providers and others listed on this form as it applies to:

☐ All my client records, including reproductive health (i.e., birth control, pregnancy, abortion); HIV/AIDS and sexually transmitted disease (STD) test results, diagnosis, or treatment; mental health; and chemical dependency.

OR

Only the following records (check all that apply):

☐ HIV/AIDS and STD test results, diagnosis, or treatment
☐ Reproductive health
☐ Mental health
☐ Chemical dependency
☐ Other (list): _____

I also agree that the health care providers and others listed on this form may share my health information with each other, and cannot share it with anyone who is not listed on this form. I can change my mind and take back my consent at any time by updating page 2 of this form and giving it to my Health Home care coordinator. This will not affect any information already shared. Initials: _____

Unless previously revoked by me, the specific information above is valid until:

☐ I am no longer participating in Health Homes.

☐ Or until _____ (enter expiration date).

Print name of client	Client's date of birth
Client or legal representative's signature	Date
Print name of legal representative	Relationship of legal representative to client

If you think someone used your information and you did not agree to give the person your information, call your care coordinator or the Medical Assistance Customer Services Center (MACSC) toll-free line at 1-800-562-3022 (TTY: 1-800-848-5429).

Print name of client

List the names of participating health care providers and others	Client gives consent		Client withdraws consent	
	Date	Client's initials	Date	Client's initials
Children's Administration social worker				
Natural parent, adoptive parent, foster parent				
Primary care provider				
Managed care organization				
Past managed care organization				
Health Home care coordinator/lead				
Past Health Home care coordinator/lead				
Tribal social worker/director				
Family planning provider				
Chemical dependency provider				
Mental health provider				
Additional care providers				

NOTICE: PROHIBITING REDISCLOSURE OF CONFIDENTIAL ALCOHOL- OR DRUG-TREATMENT INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol- or drug-abuse patient.