**Information Sharing Authorization Form**

**for the OHP Health Related Social Needs Benefit**

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| --- | --- | --- | --- | --- | --- |
| First Name | Last Name(s) | | | Date of Birth | |
| Mailing Address | | City | State | | ZIP Code |
| Phone Number(s) | Email | | | OHP Medicaid ID: | |

The Oregon Health Plan (OHP) covers Health-Related Social Needs (HRSN) services at no cost to you. HRSN services are items and supports such as:

* Portable power supplies
* Mini refrigeration units to keep medication cold
* Meals that follow a special diet for your medical condition
* Housing support

HRSN Service Providers are organizations or individuals that give you HRSN services.

**By using this form, you authorize (allow) sharing of your health information and other confidential information only for the purposes listed in Part 1 below.**

**By signing, you authorize (allow) only certain organizations and individuals to share your information. They must share the minimum (least) amount of your information needed to arrange HRSN services**.

Signing this form does **not:**

* Allow anyone to share your information with law enforcement or immigration authorities.
* Mean you agree to pay for any HRSN benefits.

1. **Purposes of Sharing Information.**By signing, you authorize (allow) sharing of your health information and other confidential information to be used to:
   1. Determine if you are eligible for HRSN services;
   2. Refer you to, provide you with, or help you access HRSN services; and
   3. Identify, support, coordinate, improve, and pay for HRSN services to be provided to you.
2. **Information to be Shared.**By signing, you authorize (allow) sharing of the following types of information about you as needed for the purposes outlined in Part 1.
   1. Demographic information. This includes your name, age, date of birth, address and contact information. This also includes any accessibility needs, such as whether you need help in a different language or format, to access services. This information can help connect you to an HRSN Service Provider who understands your language or culture.
   2. Certain protected health information (PHI). This could be information about your Medicaid eligibility. It could also be information about your medical history. This includes lab test results, medication use, conditions, and treatments. This kind of information is only shared when necessary.
   3. HRSN-specific information. This includes the reasons that qualify you for HRSN services, such as health conditions or life circumstances. It also includes the HRSN services you can get and the HRSN Service Providers who worked with you.
   4. Mental health information. This may include your mental health diagnoses, condition, and treatments. It will only be shared when necessary. *This* *does not include psychotherapy notes. You must give further consent for sharing such notes*.
   5. Substance use disorder information. This may include your current and past alcohol or drug use, relevant diagnoses, your condition, related treatment you received or are receiving, medications and outpatient and residential treatment programs. It may also include information about trauma you have experienced during your life that affected or affects your alcohol or drug use.  *Substance/alcohol use disorder information about you that comes from providers who must follow federal substance use confidentiality regulations (42 C.F.R. Part 2) can be shared ONLY IF you check the box at the end of this form.*
   6. Housing/homelessness information, including your housing status, history, and supports.
3. **Care Partners Who Will Share or Receive Your Information.** By signing, you allow the people and organizations involved in your health care, HRSN services, and care coordination (Care Partners) to share and receive your information. They may only share your information for the purposes described in Part 1 of this form. Care Partners and their contractors agree to obey all laws about protecting your information and resharing your information. Your Care Partners may include the following:
   1. Health care providers. These may include hospitals, clinics, physicians, pharmacies, dentists, and behavioral health providers.
   2. Oregon Health Authority (OHA).
   3. OHA’s administrator for OHP Open Card (Fee-for-Service) benefits and payments.
   4. HRSN Service Providers and vendors who may deliver or provide you with HRSN services or items, such as air conditioner units, under the HRSN benefit. Attachment A lists these providers.
4. **Length of Authorization.** Once signed, this form will be effective until one of the following occurs, whichever happens first:
   1. Twelve (12) months pass from the date you signed this form.
   2. You cancel this form. To do this, send a request by phone to 888-834-4304, by email to ORHRSN@kepro.com, or by fax to 833-551-2607.
   3. You make any change to this form. The new form becomes effective the date you send the changes. You can send the changes by phone to 888-834-4304, by email to ORHRSN@kepro.com, or by fax to 833-551-2607.
5. **Your Rights.** By signing, you understand and agree that:
   1. You can cancel or change this form at any time by calling 888-834-4304, emailing ORHRSN@kepro.com, or faxing 833-551-2607.
   2. If you cancel this form, Care Partners cannot recall or delete any information they already shared, reshared, or received.
   3. You have a right to receive a copy of this form.
   4. Your Care Partners can share and reshare your information with other people or entities, but only as allowed by law or as described in this form.
   5. You can get a list of the Care Partners who have received your information. To ask for this list, call 888-834-4304, email ORHRSN@kepro.com, or fax 833-551-2607.

***You may decline to sign this form. If you decline to sign this form, your Open Card team will give you a copy of your HRSN Service authorization approval and you will have to ask the HRSN Services Provider directly for the approved services.***

***Even if you choose to not sign this form, you***:

* + Will receive all your benefits, treatment, or care.
  + Will receive a decision of whether you are approved or denied for HRSN services.
  + Will **not** have to pay for HRSN services.

**\* \* \* \* \* \***

**By signing this form, I authorize (allow) my Care Partners to use and share my health information and other confidential information for the purposes described in Part 1 of this form.**

**If I voluntarily list my phone number on this form, I consent to receiving texts or calls from my Care Partners (standard message and data rates may apply). My Care Partners may text or call this number to tell me about:**

* **My consent choices and**
* **How my information may be shared.**

**☐ By checking this box, I also authorize (allow) the sharing of substance use disorder information about me that comes from providers subject to federal substance use confidentiality regulations (42 C.F.R. Part 2).**

*If you are signing on your own behalf, fill out the first line. If you are signing on behalf of someone else, fill out the second and third lines.*

|  |  |  |
| --- | --- | --- |
| Member’s Name | Member’s Signature | Date (mm/dd/yyyy) |
| Representative’s Name | Representative’s Signature | Date (mm/dd/yyyy) |
| Representative’s Relationship to / Description of Authority over Member | | |

**Attachments**

1. Lists of HRSN Service Providers
2. Frequently Asked Questions (FAQs)