UMPQUA HEALTH

Need help with this form?
Call us at 541-229-4842 and ask for a Care Coordinator.

Oregon Health Plan Health-Related Social Needs Services

Information Sharing Authorization Form

First & Last Name:

Date of Birth:

Mailing Address (City, State, Zip):

Phone Number: **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:

- An air conditioner
- A mini refrigerator for medications
- Special meals for your health condition
- Housing support

HRSN service providers are entities or people that give HRSN services. If you fill out this form and consent below you will authorize (allow):

- Sharing of your health information and other confidential information only for the purposes in Part 1 below.
- Certain entities and people to share your information. They must share the least amount needed to arrange HRSN services.

Consenting to this form does **not:**

- Allow anyone to share your information with police or immigration agencies.
- Mean you agree to pay for any HRSN benefits.

We can provide help at no cost to you. If you need another language, large print, Braille, CD, tape or another format, or an interpreter, call Customer Care at 541-229-4842; Toll Free: 866-672-1551; TTY: 541-440-6304 or 711, Monday to Friday 8am to 5pm.

Part 1. Purposes of sharing information.

By consenting, you authorize (allow) your health information and other confidential information to be shared to:

- Determine if you are eligible for HRSN services
- Refer you to, help you access, or get HRSN services, and
- Identify, support, coordinate, change and pay for HRSN services for you.

Part 2. Types of information shared.

By consenting, you authorize (allow) the following types of information about you to be shared as needed for the purposes in Part 1. This information is only shared when necessary.

1. Demographic information. This includes:
    a. Name
    b. Age
    c. Date of birth
    d. Address
    e. Contact information, and
    f. Any accessibility needs, such as help in a different language or format, to access services. This can help connect you to an HRSN service provider who understands your language or culture.
2. Certain protected health information (PHI). This may include:
    a. Your Medicaid (OHP) eligibility
    b. Your medical history:
    c. Lab test results
    d. Medication use
    e. Health conditions, and
    f. Treatments.
3. HRSN-specific information. This includes:
    a. The reasons you qualify for HRSN services, such as health conditions or life circumstances
    b. The HRSN services you can get, and
    c. The HRSN service providers who worked with you.
4. Mental health information. This may include:
    a. Your mental health diagnoses 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:
    a. Your current and past alcohol or drug use
    b. Diagnoses
    c. Medications, and
    d. Outpatient and residential treatment programs, and
    e. Information about the trauma you have experienced that affected or affects your alcohol or drug use.

    Substance or alcohol use disorder information about you 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 information. This includes your housing:
    a. Status
    b. History, and
    c. Supports.

Part 3. Care Partners who share or get your information.

By consenting, you authorize (allow) the following Care Partners to share and get your information:

- People and entities involved in your:
  - Health care,
  - HRSN services, and
  - Care coordination.

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 sharing your information. Your Care Partners may include the following:

1. Health care providers. These may include:
   a. Hospitals
   b. Clinics
   c. Physicians
   d. Pharmacies
   e. Dentists, and
   f. Behavioral health providers.
2. Oregon Health Authority (OHA).
3. OHA's administrator, Acentra Health, for OHP "Open Card" (fee-for-service) benefits and payments.
4. HRSN service providers and vendors who may deliver or provide HRSN services or items, such as air conditioner units, under the HRSN benefit. Attachment A lists these providers.

Part 4. Length of authorization.

Once you sign this form it is effective until one of these happens:

1. 12 months pass from the date you signed this form.
2. You revoke (cancel) this form. You can do so by contacting UHA at:
   a. Email: hrsn@umpquahealth.com
   b. Phone: 541.229.4842
3. You make any change to this form. The new form becomes effective on the date you send the changes. You can do so by downloading a copy of the form at www.umpquahealth.com/hrsn, filling it out, and sending a copy to hrsn@umpquahealth.com.

Part 5. Your Rights.

By consenting, you understand and agree that:

1. You can revoke (cancel) or change this form at any time in any of the following ways:
   a. Email or call UHA at:
      i. Email: hrsn@umpquahealth.com
      ii. Phone: 541.229.4842
   b. Download a new copy of the form at www.umpquahealth.com/hrsn, fill it out, and send a copy to hrsn@umpquahealth.com.
2. If you revoke (cancel) this form, Care Partners cannot stop or delete any information already shared, reshared, or received.
3. You have a right to get a copy of this form.

4. Your Care Partners can share and reshare your information with other people or entities. However, they can only do so as the law allows or as stated in this form.
5. You can get a list of Care Partners who have received your information. To ask for this list, do so in any of the following ways:
    a. Call 541.229.4842
    b. Email hrsn@umpquahealth.com

You don't have to consent to this form. If you don't consent to this form, your CCO will give you a copy of your HRSN service authorization approval. You will need to ask the HRSN services provider directly for the approved services.

Even if you choose to not consent to this form, you:

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

If I willingly list my phone number on this form, I consent to 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.

Form Consent

Do you authorize (allow) your Care Partners to use and share your health information and other confidential information for the purposes in Part 1 of this form?

◯ Yes ◯ No

Do you also authorize (allow) the sharing of substance use disorder information about you that comes from providers subject to federal substance use confidentiality regulations (42 C.F.R. Part 2)?

◯ Yes ◯ No

If you sign for yourself:
Member Name (print):

Member Signature: **Date:**

If you sign for someone else:
Representative's Name (print):

Relationship to Member:

Representative's Signature: **Date:**