Election to Participate in Care Coordination

Consent/Authorization to Disclose Records

1. CAREFIRST'S CARE COORDINATION

To help you manage your care it is essential for you and your health care providers to have a complete picture of existing and potential health risks for working together to produce better health outcomes. This begins with strong communication between you, your health care provider and CareFirst.

To foster and improve that communication, CareFirst has created a secure, confidential Member Health Record (MHR) for use by your health care providers as a common source of your health information while you participate in CareFirst's Care Coordination program and related clinical programs. By electing to participate with your provider in CareFirst's Care Coordination program, and other supporting clinical programs, you facilitate this communication and allow your health care team (including your primary care provider and other providers and health care professionals providing services for you) and CareFirst to see information in the MHR and to appropriately share that information with each other in a secure and confidential manner to help coordinate and manage your health care. CareFirst limits the information disclosed to that which is necessary to carry out this purpose.

2. CONSENT/AUTHORIZATION

I understand that:

- My participation is voluntary. I may choose not to participate CareFirst's Care Coordination and still maintain my insurance coverage with CareFirst.

- CareFirst will not condition payment of medical benefits, enrollment, or eligibility of medical benefits on my participation in the Program.

- CareFirst may disclose my personal health information as required or allowed by law.

- CareFirst may share data and information supplied by health care providers (for example: a health care professional, hospital, clinic, laboratory, pharmacy, or medical facility) who have provided treatment or services on my behalf. It may also include the results of my Health Assessment and/or Wellness Screening provided through a contracted CareFirst health care partner.

- My health care provider, including my treating mental health and substance use disorder providers, may share my information with CareFirst.

2. CONSENT/AUTHORIZATION (CONTINUED)

- Information about me that could be disclosed includes information contained in my general medical record, my mental health information, including substance use disorder, and health care claims as a result of: medical encounters, treatments, diagnostic tests, screenings, prescriptions, patient-centered medical home, and other case management activities.

- It may also include, but will not necessarily be limited to, any of my medical records related to:
  - Drug, alcohol or substance use disorder;
  - Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excluding “psychotherapy notes”);
  - Metabolic disorders such as sickle cell anemia;
  - Birth control and family planning;
  - Records which may indicate the presence of a communicable disease or non-communicable disease;
  - Records of HIV/AIDS or sexually transmitted diseases;
  - Genetic (inherited) diseases or tests; and laboratory test results directly from the clinical laboratory.

2. CONSENT/AUTHORIZATION (CONTINUED)

- This sharing of information for purposes of my care and treatment is provided for and permitted under the privacy rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

- All members of my Care Coordination Team will have access to my medical information solely for my care and treatment. Health care providers and CareFirst's health care related contracted partners are required by law to maintain the privacy of my medical information consistent with applicable federal and state privacy laws, including HIPAA privacy rules. CareFirst cannot control unauthorized re-disclosures of my information by persons to whom CareFirst discloses such information.

- I may participate in clinical programs as requested by my provider without having to sign additional election to participate forms. I may decline to participate in any of these services at any time.

- I will be an active participant in decisions relative to my ongoing medical care, treatment for chronic conditions and improvement of my health status.

2. CONSENT/AUTHORIZATION (CONTINUED)

- I have the right to inspect any record of my mental health medical information.

- I understand that, upon my request and consistent with 42 CFR Part 2, I will be provided a list of entities to which my substance use disorder records have been disclosed.

- I understand that I may revoke this authorization at any time without adverse consequences by completing a Revocation Form found at **carefirst.com/memberpcmh**. Click on Participate in PCMH. This revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that my health plan has already used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in my health plan and, by law, the health plan has a right to contest the coverage.

- This consent will expire after one year if not revoked.

2. CONSENT/AUTHORIZATION (CONTINUED)

- By providing my phone number and email address, I understand that CareFirst and its partners may contact me regarding my medical care by phone, cell phone, text messaging or email. I understand that consent to contact me survives the expiration of this Election to Participate unless I otherwise revoke consent.

3. CLAIMS

I authorize CareCo and my other mental health and substance use disorder providers to disclose to CareFirst my mental health information, including substance use disorder, necessary for processing claims. The information to be disclosed is limited to:

- Administrative information;
- Diagnostic information;
- My status (voluntary or involuntary);
- Reason for admission or continuing treatment; and
- A prognosis limited to the estimated time during which treatment might continue.

4. SIGNATURE
Please keep a copy of this form. Contact your CareFirst Care Coordinator with questions regarding this form.
Member Signature*
Printed Member Name
Member Date of Birth (DOB)
Member ID
Date
Parent/Guardian Signature
Printed Parent/Guardian Name
Phone Number
Cell Phone
Date
E-mail Address

5. NOTICE TO RECIPIENTS

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. Maryland law prohibits re-disclosure of medical information without authorization from the member. The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978 (§§7- 1201.01 to 7-1207.02). 42 CFR part 2 prohibits unauthorized disclosure of these records.

6. EXECUTION BY MINORS OR GUARDIANS

If the person signing this form is not the member, the parent, or guardian of a dependent under the age of 18, you must submit, to the address above, a full copy of the official document indicating your legal authority to sign on behalf of the member (i.e. Power of Attorney, Court Assigned guardian, Personal Representative, etc.).

*If the parent or guardian has not consented to the provision of services and instead the minor has provided legally sufficient consent, the minor may authorize disclosure him or herself. When the minor has consented to such treatment, except by specific legal requirement, no information regarding sexually transmitted disease, substance use, pregnancy, or emotional illness shall be disclosed unless such information is necessary to the health of the minor and the public, and only when the minor's identity is kept confidential. In D.C. and Virginia, if this consent relates to mental health information (including inpatient psychiatric hospitalization when the minor is 14 years or older and has consented to the admission), and the patient to whom this consent applies is over the age of 14 and under the age of 18, the minor and his or her custodial parent must provide joint consent.

6. EXECUTION BY MINORS OR GUARDIANS (CONTINUED)

In D.C., if the patient is less than 14 years of age, then only the parent or guardian must provide consent. In Virginia, the concurrent consent of a minor and his or her custodial parent is required to disclose inpatient substance use disorder records.