# Authorization to Share Confidential Medi-Cal Information (ASCMI)

## Version 1.0 [Pilot]

*December 2022*

*Disclaimer: The ASCMI Form is intended to be used solely by ASCMI Pilot participants. DHCS makes no representation about the suitability of this form for uses outside of the ASCMI Pilot. The ASCMI Form, including attachments, are subject to change.*

| First Name | Last Name | Date of Birth | |
|---|---|---|---|
| Mailing Address | City | State | Zip Code |
| Residential Address | City | State | Zip Code |
| Phone Number(s) | Email | Beneficiary Identification Card (BIC) | |

By signing this form, you authorize certain organizations and individuals to use and share your health and other confidential information for the purposes described in section 1.

### 1. Purposes

*By signing, you authorize your health and other confidential information to be shared only to:*

(a) Provide you with, refer you to, or help you access healthcare treatment, benefits, programs, social services, case management, community resources, and other supports ("Services") to meet your needs.

(b) Identify, support, coordinate, improve, and arrange payment for Services that may be provided to you.

(c) Help Medi-Cal provide better care through evaluation, reporting, and population health management.

### 2. Types of Your Information that You Authorize to be Shared

*By signing, you authorize the below types of health and other confidential information about you to be shared only for the purposes stated above.*

(a) Protected health information (PHI), including information regarding your health care, medical history, lab test results, and current or future conditions and treatments.

(b) Mental health information, including current and past diagnoses and treatments of your mental health conditions. This does not include psychotherapy notes, which are only shared if you separately consent.

(c) Substance use disorder information, including your current and past alcohol or drug use diagnoses, medications, treatment, lab tests, trauma history, facility discharges. This includes substance use disorder information about you that comes from a substance/alcohol use disorder provider subject to federal substance use confidentiality regulations (42 C.F.R. Part 2) if you check the box at the end of this form.

(d) Individualized Education Programs, and other information about social services provided in schools.

(e) Medi-Cal eligibility/enrollment information, which includes income and certain other demographic and geographic information pertaining to your eligibility for Services and benefits.

(f) Housing/homelessness information, including your housing status, history, and supports.

(g) Limited criminal justice information, including booking data, dates and location of incarceration, and supervision status. Your consent does not apply to your criminal history, charges, and immigration status.

**3. Sources and Recipients of Your Information**

*By signing, you agree to allow a health information exchange or community information exchange ("HIE/CIE") facilitate the exchange of your health and other confidential information with and between your care partners from which you have received, are receiving, or will receive benefits, treatment, or services (""Your Care Partners"). Information may be shared only for the purposes in part 1. Your Care Partners may include the following:*

(a) Healthcare providers, such as hospitals, clinics, physicians, pharmacies, and behavioral health providers.

(b) Managed care plans (MCPs), which administer Medi-Cal benefits and pay for services you receive under Medi-Cal.

(c) Certain community-based organizations (CBOs) that must comply with federal health care privacy laws, including some medically tailored meal providers, housing providers, and asthma remediation providers.

(d) School-based providers of health or social services, such as nurses, social workers, and counselors.
(e) State health agencies, specifically, the California Departments of Health Care Services, Public Health, Social Services, and Developmental Services.
(f) County agencies, including mental health plans, human/social services or welfare departments, drug Medi-Cal organized delivery systems, and health and public health departments.
(g) Providers & case managers at correctional facilities, such as those at jails, prisons, and youth correctional facilities, only for the purposes in part 1 of this form. You do not consent to the use of your information for criminal investigations or prosecutions, sentencing, parole or probation monitoring, immigration enforcement, or family court proceedings.

Your Care Partners and their contractors agree to obey all applicable laws protecting your information.

**4. Expiration, Revocation, or Change of This Form**

*Once signed, this form will be effective until the first of the following occurs:*

(a) 24 months from the date on which you were last enrolled in Medi-Cal;
(b) you revoke this form; or
(c) you make any change to this form, and the modified form becomes effective.

**5. Your Rights**

*You understand that:*

(a) you can revoke this form at any time through the consent management service portal or by sending a revocation request signed by you or your representative to the HIE/CIE. ;
(b) a revocation is effective when received but may not apply to information already shared based on your past executed form, which may not be recalled or deleted;
(c) you may decline to sign this form and doing so will not affect your treatment or care, your eligibility for or ability to receive Services, or the payment for Services;
(d) you have a right to receive a copy of this form;
(e) the information you authorize for release could be re-disclosed by Your Care Partners, but only in compliance with this form and applicable law; and
(f) you may obtain a list of Your Care Partners to which your information has been disclosed by contacting the HIE/CIE.

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Each of these rights extend to your representative if authorized by you under applicable law.

**6. Sharing Information Without Your Consent**

You understand that even if you do not sign this form, under federal and state privacy laws some of Your Care Partners may share your confidential information for treatment, payment, and other purposes, but providers subject to federal substance use confidentiality laws generally may not share your substance use disorder information without your consent.

**7. Authorization**

By signing this form, I authorize certain organizations and individuals to use and share my health and other confidential information for purposes described in part 1 of this form. Also, if I voluntarily include my phone number above, I consent to the receipt of texts or calls to communicate with me about my consent choices and how my information may be shared (standard message and data rates may apply).

☐ By checking this box, I also authorize the disclosure 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 1st line. If you are signing on behalf of someone else, fill out the 2nd line. If you are signing on behalf of a minor aged 12-18, the minor should fill out the 1st line and you should fill out the 2nd line.*

| Beneficiary's Name | Beneficiary's Signature | Date (mm/dd/yyyy) |
|---|---|---|
| Representative's Name | Representative's Signature | Date (mm/dd/yyyy) |