# Health Home Enrollment and Information Sharing Consent

For Use with Children Under 18 Years of Age

This form must be used for children less than 18 years of age for enrollment in a Health Home. This form also outlines what, and with whom, health information can be shared.

**Please note, children less than 18 years of age who are parents, pregnant, and/or married, and who are otherwise capable of consenting, should not use this form. Rather, they must use the *Health Home Patient Information Sharing Consent* form (DOH-5055).**

## INSTRUCTIONS FOR PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE:

*Section 1* of this form should be completed by the child's Parent, Guardian, or Legally Authorized Representative. Legally Authorized Representative for the purpose of sharing health information is defined as "a person or agency authorized by state, tribal, military or other applicable law, court order or consent to act on behalf of a person for the release of medical information". List all of the child's health providers who can share the child's health information. The health information they share may be from before and after the date you sign this form. These providers can share this information with each other and with the child's care management agency listed below. They cannot give the child's information to other people unless you agree, or the law says they can. The child can keep private any information about services that the child consents for outlined in Section 2, including family planning and emergency contraception, abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services. If you consented for any of these services for the child, then you may have the authority to consent to the release of information regarding these services and can list the providers in this Section. **Note:** the child may have to consent to the release of this information also.

*Section 2* of this form is completed separately by the child with the care manager. *Children age 10 or older can consent to share or withhold information regarding certain types of protected services. In addition, if the child or adolescent is specifically receiving services for mental health or developmental disabilities and is over the age of 12, the mental health and/or developmental disabilities provider may ask the child or adolescent if they want their information disclosed.*

## INSTRUCTIONS FOR CARE MANAGER:

*Section 1* is completed by the child's Parent, Guardian, or Legally Authorized Representative. It lists all health providers who can share the child's health information. List the child's care management agency as a provider below. These providers can share all health information except for any information about services the child can self-consent for, including family planning and emergency contraception, abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services. If the Parent, Guardian, or Legally Authorized Representative consented to abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, or drug and alcohol treatment on behalf of the child, information can only be released ***if the child also consents*** to the release in *Section 2*. Copy the page below as needed to be able to list all agreed to providers. If this list needs to be updated in the future (to either add or remove a name), please have the Parent/Guardian/Legally Authorized Representative select either ***ADD*** or ***REMOVE***, initial and date next to each new entry or omission. *The HHCM must also initial next to each change made.*

## INSTRUCTIONS FOR PARTICIPATING PROVIDER:

If your name or agency is listed in *Section 1*, you may release the child's health information except for any information about services the child can self-consent for, including family planning and emergency contraception, abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services. You may only release this information if you are given permission to do so in *Section 2* of this form. If the Parent, Guardian, or Legally Authorized Representative consented to abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, or drug and alcohol treatment on behalf of the child, information can only be released ***if the child also consents*** to the release in *Section 2*. If you receive a copy of *Section 2* of this consent form, please review it carefully to identify permission provided by the child for the Health Home Care Manager to share specific information with you. **NOTE:** If *Section 2* is NOT provided, permission has not been granted by the child and therefore, this information may NOT be released or shared with you.

**Name of Health Home** (Print): _____

**Name of Child** (Print): _____ **Child's Date of Birth:** _____

**SECTION 1:** This section is completed by the child's Parent, Guardian, or Legally Authorized Representative. By signing this form, I agree that:

**1.** It has been explained to me that the child named above is qualified to be in a Health Home.

**2.** The child listed above is enrolled in the Health Home listed above.

**3.** I have had the chance to review the Health Home FAQ sheet and have had my questions answered.

**4.** I understand what the Health Home Program is and how it can help the child. I understand what being enrolled in a Health Home means and why this child's health information will be shared.

**5.** The Health Home and anyone I have named in the *Section 1* below can share _____ health information, as outlined in the Instructions above with each other for the purposes of care management in the Health Home Program. They may share information from before or after the date I sign this form.

**6.** The Health Home may get the child's health information, including health records, from places and people that gave, or currently give, the child health care or health insurance. These may include hospitals, doctors, pharmacies, laboratories, health plans (insurance companies), the Medicaid program, dentists, and other partners listed at the end of this form and/or from others through the following electronic systems:

- The Statewide Health Information Network for New York (SHIN-NY): The SHIN-NY is run by the New York State Department of Health. The SHIN-NY collects and stores health information, including medical records, from their doctors and health care providers;
- The Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES): PYSKCES is run by the New York State Office of Mental Health, collects and stores your health treatment from your doctors and health care providers who are part of the Medicaid program;
- The Uniform Assessment System NY (UASNY): The UASNY is run by the New York State Department of Health. The UASNY is a secure statewide database that captures and stores identifying information and completed assessments for each individual that receives services;
- TABS/CHOICES: TABS/CHOICES is run by the New York State Office for People With Developmental Disabilities (OPWDD). TABS/CHOICES collects and stores information for people with intellectual and/or developmental disabilities (I/DD) served through OPWDD's service system.

**7.** In addition, the Health Home may need to share the child's information with the local Single Point of Access (SPOA) to help the Health Home Care Manager coordinate access to needed mental health services. The SPOA is able to see data under Mental Hygiene Law Section 41.05 and pursuant to the authority of Sections 41.07 and 41.13. Permission to contact the SPOA can be provided on the Provider page below.

I understand that this consent form takes the place of other Health Home information sharing consent forms I may have signed before on behalf of the child. This consent stays in place until:

- I withdraw the child, or
- The child is no longer eligible for a Health Home, or
- The Health Home is no longer in business, or
- The child becomes the age or situation to self-consent (complete DOH-5055)

I can change this form at any time. If I make changes, I have to initial and date as indicated (or within the designated box). I can always take back this consent on behalf of the child by contacting the Care Manager, Care Management Agency, or Health Home.

**If I do not sign this consent form, I understand that the child's information will not be shared.**

**Name of Child's Parent, Guardian or Legally Authorized Representative** (Print): _____

**Relationship of Parent, Guardian or Legally Authorized Representative to Child:** _____

**Signature of Child's Parent, Guardian or Legally Authorized Representative:** _____ **Date:** _____

**Name of Health Home** (Print)**:** _____

**Member Name** (Print)**:** _____

**Copy this page as necessary to list all participating partners and others approved by the member's Parent, Guardian or Legally Authorized Representative.**

| List all of the child's health providers who can share the child's health information below. The health information they share may be from before or after the date you sign this form. These providers can share this information with each other and with the child's care management agency listed below. | If at ANY time there are changes to this page, the Parent, Guardian, or Legally Authorized Representative **MUST** select whether the change is to ADD or REMOVE provider, and DATE and INITIAL next to the change(s) made in the box belo The Health Home Care Manager (HHCM) must also INITIAL all changes. | | | |
|---|---|---|---|---|
| | **Add or Remove** | **Date of Change** | **Initials of Parent, Guardian, or Legally Authorized Representative** | **Initials of HHCM** |
| **Health Home Care Management Agency:** | ☐ Add<br>☐ Remove | | | |
| **Medicaid Managed Care Plan:** | ☐ Add<br>☐ Remove | | | |
| **Name of Primary Care Physician:** | ☐ Add<br>☐ Remove | | | |
| **Name of Hospital:** | ☐ Add<br>☐ Remove | | | |
| **Name of Foster Care Agency:** | ☐ Add<br>☐ Remove | | | |
| **Name of Behavioral Health Provider:** | ☐ Add<br>☐ Remove | | | |
| **Name of SPOA/LGU:** | ☐ Add<br>☐ Remove | | | |
| **Name of Provider:** | ☐ Add<br>☐ Remove | | | |
| **Name of Provider:** | ☐ Add<br>☐ Remove | | | |
| **Name of Provider:** | ☐ Add<br>☐ Remove | | | |
| **Name of Provider:** | ☐ Add<br>☐ Remove | | | |
| **Name of Provider:** | ☐ Add<br>☐ Remove | | | |
| **Name of Provider:** | ☐ Add<br>☐ Remove | | | |
| **Name of Provider:** | ☐ Add<br>☐ Remove | | | |
| **Name of Provider:** | ☐ Add<br>☐ Remove | | | |

**TO BE COMPLETED WITH CHILD ONLY**

**Section 2: The child/youth must be age 10 or older to review and complete this section.**

## INSTRUCTIONS

Section 2 should be completed after Section 1 has been completed and signed by all necessary parties. To complete Section 2, the child/youth must be age 10 or older. Section 2 of this form should be completed by the Health Home Care Manager with the child. Completion of this form should be done in private, without the child's Parent, Guardian, or Legally Authorized Representative, to allow for confidentiality of the information.

**Section 2 – Part A:** Children age 10 or older can consent to share or withhold information regarding certain types of protected services as follows: Family Planning; Emergency Contraception; Abortion; HIV Testing and Treatment Provider(s); HIV Prevention Pre-exposure and Post-exposure Prophylaxis (PrEP/PEP); Sexually Transmitted Infection Testing and Treatment: Prenatal Care, Labor/Delivery; Drug and Alcohol Treatment; Sexual Assault Services.

**Section 2 – Part B:** Children age 12 or older can consent to share or withhold information regarding mental health or developmental disabilities services they are receiving. The mental health and/or developmental disabilities provider may ask the child or adolescent if they want their information disclosed.

**Section 2 – Parts A and B *MUST* be completed *unless*:** the child does not meet the specified age requirement (age 10 or age 12); the child is unwilling or unable to complete this section; the child does not identify any protected services; the child does not identify any mental health or developmental disabilities services; OR, permission is denied by the child's Parent/Guardian/Legally Authorized Representative to have the HHCM meet alone with the child for review of Section 2. If any of these reasons apply, the HHCM ***MUST*** clearly document the reason(s) in the child's record and complete the *Health Home Care Management Tracker For Section 2*, and continue with attempts to obtain this information at a later date to assist the member with coordinating these services.

## SECTION 2 PART A

**I, _____ , understand that I can consent for certain types of health care services without my Parent, Guardian, or Legally Authorized Representative knowing.** These services are: Family Planning; Emergency Contraception; Abortion; HIV Testing and Treatment Provider(s); HIV Prevention Pre-exposure and Post-exposure Prophylaxis (PrEP/PEP); Sexually Transmitted Infection Testing and Treatment: Prenatal Care, Labor/Delivery; Drug and Alcohol Treatment; Sexual Assault Services. **I can also decide who is allowed to get and share my information about these services.**

| **It is okay to share information about these services with my Parent, Guardian or Legally Authorized Representative named below.** | Any changes made in this section must be initialed and dated by the child and the Health Home Care Manager (HHCM) below.<br>I take away my permission to share information about these services with my Parent, Guardian or Legally Authorized Representative, as follows: |
|---|---|

| Types of Services and Name(s) of Provider and/or Agency | Date | Name of Parent, Guardian or Legally Authorized Representative | Child's Initials | Date | HHCM Initials | Date |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| **It is okay to share information about these services with my Provider(s) named below.** | | | Any changes made in this section must be initialed and dated by the child and the Health Home Care Manager (HHCM) below.<br>I take away my permission to share information about these services with the Provider, as follows: | | | |
|---|---|---|---|---|---|---|
| **Types of Services and Name(s) of Provider and/or Agency** | **Date** | **Name of Parent, Guardian or Legally Authorized Representative** | **Child's Initials** | **Date** | **HHCM Initials** | **Date** |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## SECTION 2 PART B

If you are receiving mental health and/or developmental disabilities services, and are over the age of twelve, your provider may ask you if you want your information shared with others. If you object, your provider may: deny the request entirely, send only part of the record, or send a summary of your clinical record.

| **It is okay to share information about these services with my Parent, Guardian or Legally Authorized Representative named below:** | | | Any changes made in this section must be initialed and dated by the child and the Health Home Care Manager (HHCM) below.<br>I take away my permission to share information about these services with my Parent, Guardian or Legally Authorized Representative, as follows: | | | |
|---|---|---|---|---|---|---|
| **Types of Services and Name(s) of Provider and/or Agency** | **Date** | **Name of Parent, Guardian or Legally Authorized Representative** | **Child's Initials** | **Date** | **HHCM Initials** | **Date** |
| **Mental Health Services:** | | | | | | |
| **Developmental Disability Services:** | | | | | | |

| **It is okay to share information about these services with the Provider(s) named below:** | | | Any changes made in this section must be initialed and dated by the child and the Health Home Care Manager (HHCM) below.<br>I take away my permission to share information about these services with the Provider, as follows: | | | |
|---|---|---|---|---|---|---|
| **Types of Services and Name(s) of Provider and/or Agency** | **Date** | **Name of Parent, Guardian or Legally Authorized Representative** | **Child's Initials** | **Date** | **HHCM Initials** | **Date** |
| **Mental Health Services:** | | | | | | |
| **Developmental Disability Services:** | | | | | | |

**By signing Section 2 of this form, I agree that:**

1. I have had the chance to review the Health Home FAQ sheet and have had my questions answered, and
2. The Health Home and anyone I have named in *Section 2* of this form can share my health information as listed above. They may share information from before and after the date I sign this form.

I can change *Section 2* of this form at any time. If I make changes, I have to initial and date next to those changes (or within the designated box).

I understand that this consent form, *Section 2*, takes the place of other Health Home information sharing consent forms, *Section 2*, I may have signed before. *Section 2* stays in place until:

- I withdraw it, or
- I am no longer eligible for a Health Home, or
- The Health Home is no longer in business, or
- My Parent, Guardian or Legally Authorized Representative removes me from the Health Home program, or
- I become the age or situation to self-consent (complete DOH-5055).

**Name of Child** (Print)**:** _____ **Child's Date of Birth:** _____

**Signature of Child:** _____ **Date:** _____

**Name of Health Home Care Manager** (Print)**:** _____

**Signature of Health Home Care Manager:** _____ **Date:** _____