

NC Department of Health and Human Services

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION PURPOSES

(For Use by DMH/DD/SAS Facilities)

Client Name _____ Date of Birth _____

Client Medical Record # _____ Client SS # _____

I give my voluntary consent for _____ to use (Name of DMH/DD/SAS Provider)

and disclose health information regarding _____ (Client Name)

to the following agencies/individuals when applicable for purposes of treatment*, payment** (including benefit payment and for establishment of entitlements) and health care operations***: Social Security Administration, my Social Security Benefit Representative Payee, Civil Service, Medicaid, Medicare, Veterans Administration, Armed Services, State Employee Health Plan, Disability Determination Office, Railroad Retirement, Blue Cross/Blue Shield, any other health or benefit program for determination of coverage and for disclosure of information related to payment activities, this agency's Human Rights Committee, community agencies that may need to provide services to aid in my treatment or payment such as County Dept. of Social Services, Vocational Rehabilitation, Area Agencies on Aging, educational sources (e.g., schools, teachers, counselors), any health care providers my treatment/habilitation team may refer me to or request information from for treatment purposes (e.g., hospitals, clinics, labs, physicians, psychologists, area programs) and any of the following agencies/individuals not listed above:

_____. I also consent for you to disclose information relevant to payment activities to the person responsible for payment of my bills (guarantor) if different from myself _____ (Guarantor Name)

I understand that state and federal laws permit certain uses and disclosures for treatment, payment, and health care operations without my consent and these have been explained in the Notice of Privacy Practices that has been provided to me. I understand that the health information used and disclosed may include information such as HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, if applicable.

I understand this consent is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for payment purposes, wherein the consent is valid until the need for disclosure is satisfied. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this consent prior to the rescinded date is legal and binding.

A copy of this consent shall be considered as valid as the original.

(Signature of Client) (Date) (Witness Signature-If Required)

(Signature of Personal Representative) (Date) (Personal Representative Relationship/Authority)

(Staff Use Only)
NOTE: This Consent was revoked on: _____ (Date) _____ (Signature of Staff)

REVOCATION SECTION

I do hereby request that this consent to disclose health information of _____
(Name of Client)
signed by _____ on _____ be rescinded,
(Enter Name of Person Who Signed Consent) *(Enter Date of Signature)*
effective _____. I understand that any action taken on this consent prior to the rescinded date is legal and binding.
(Date)

(Signature of Client) _____ *(Date)* _____ *(Signature of Witness)* _____ *(Date)*

(Signature of Personal Representative) _____ *(Date)* _____ *(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this consent by _____
(Name of Client or Personal Representative)
on _____. The client or his/her personal representative has been informed that any action taken on
(Date)
this consent prior to the rescinded date is legal and binding.

(Signature of Staff) _____ *(Date)* _____ *(Signature of Witness)* _____ *(Date)*

**Treatment* means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

***Payment* means to obtain or provide reimbursement for the provision of health care; determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims; billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing; review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services; and disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement: name and address; date of birth; Social Security Number; payment history; account number; and name and address of the health care provider and/or health plan.

****Health Care Operations* include conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and clients with information about treatment alternatives; related functions that do not include treatment; reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities; conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; business planning and development such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, and development or improvement of methods of payment or coverage policies; and business management and general administrative activities of the entity, including, but not limited to: management activities relating to implementation of and compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; resolution of internal grievances; the sale, transfer, merger, or consolidation of all or part of a covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and creating de-identified health information and fundraising for the benefit of the covered entity.