MSSP - Authorization for Use and Disclosure of Protected Health Information

Participant Name: _____ MSSP ID: _____

I hereby authorize MSSP to obtain, release, use and disclose the following information about me that is protected under federal, state, and/or local laws for the following purpose(s):

- ☐ To determine my eligibility for MSSP services
- ☐ Provide care management and health/psychosocial assessment

DESCRIPTION OF PARTICIPANT'S PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED. Check all that apply.

- ☐ Physical injuries, illnesses, or conditions
- ☐ Mental (psychological or psychiatric) illnesses or conditions
- ☐ Alcohol abuse and/or drug abuse
- ☐ Cash assistance, Medi-Cal benefits or other social and health services received
- ☐ Other (if checked, must describe): _____

DISCLOSING PROVIDERS. Check all that apply. If a box is checked, provide the name of the provider.

- ☐ Medical Providers & Facilities: _____
- ☐ Social Service Providers: _____
- ☐ Medi-Cal Program(s), including IHSS county staff: _____
- ☐ IHSS Caregiver/Provider(s): _____
- ☐ Community Support Providers: _____
- ☐ Financial Institutions & Providers: _____
- ☐ Other (list provider type and name): _____
- ☐ Other (list provider type and name): _____

DISCLOSING INDIVIDUALS (include any individuals that may be sharing/receiving information regarding the participant, such as informal caregiver(s), family, friends, etc.). Check all that apply. If a box is checked, provide the name and relationship of the individual.

☐ _____ Relationship: _____

☐ _____ Relationship: _____

☐ _____ Relationship: _____

☐ _____ Relationship: _____

☐ _____ Relationship: _____

☐ _____ Relationship: _____

Participant's protected health information is being used or disclosed for the following purpose(s) by MSSP:

To determine the participant's eligibility for MSSP, for their care management, for their health/psychosocial assessments, for administrative purposes by staff, and at the request of the individual.
I understand that I have the following rights with respect to this Authorization:

1. MSSP site _____, as the recipient of the protected health information may not further disclose the information unless MSSP site _____ obtains another authorization from me or unless the disclosure is permitted by law.
2. I may not be required to sign this Authorization as a condition to obtain treatment (i.e., services) or payment or my eligibility for benefits.
3. MSSP site _____ will provide me with a copy of this Authorization.
4. I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to MSSP site _____. Such revocation will be effective upon receipt, except to the extent that MSSP site _____ has already taken action in reliance on this Authorization. Such revocation will remain in effect until I authorize, in writing, the release of the protected health information, except where the release of the protected health information is required or permitted by law.
5. I understand that once this information is released to any recipient listed on this form, it may not be protected under federal privacy law (HIPAA)

and may be further shared (i.e., subject to redisclosure) by the recipient. State or other federal law may require the recipient to obtain my authorization before further disclosure.

6. I understand that this authorization will automatically expire two (2) years from the date of this authorization regardless of any other revocation I may request.

7. MSSP site _____ will not use or disclose the protected health information for marketing or receive compensation for the use or disclosure of my protected health information without permission.

This Authorization will expire **2 (two) years from the date of signature.** *If a provider or individual permission needs to be revoked before the expiration date, initial and date the expiration date next to the provider/individual.*

ACCEPTED AND AGREED:

_____ _____ _____

Print Name **Signature** **Date**

If signed by Personal Representative:

_____ _____

Relationship **Phone**

Type of Representative:

☐ Conservator ☐ Durable and/or Medical Power of Attorney for Health Care

☐ Other:_____