Behavioral Health Care Collaborative (BHCC) Patient Information Sharing Consent

_____
Name of Behavioral Health Care Collaborative/Legal Entity

Patient Name	Patient date of Birth	Patient ID Number

By signing this form, you agree to have your health information shared by and among the _____ BHCC and its provider organizations. The goals of the BHCC initiative are to improve the integration of physical and behavioral health and to help healthcare providers improve quality of care. To support coordination of your care, health care providers and other people involved in your care need to be able to talk to each other about your care and share your health information with each other to give you better care. You will still be able to get health care and health insurance even if you do not sign this form.

The BHCC may get your health information, including your health records, from providers listed on the BHCC website: _____ and/or from others through a computer system run by the _____, a Regional Health Information Organization (RHIO) and/or a computer system called PSYCKES run by the NewYork State Office of Mental Health. A RHIO uses a computer system to collect and store your health information, including medical records, from your doctors and health care providers who are part of the RHIO. The RHIO can only share your health information with the people who you say can see or get your health information. PSYCKES is a computer system to collect and store your health information from your doctors and health care providers to help them plan and coordinate your care.
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If you give consent and sign this form, the BHCC and any of the programs within the provider organizations (see BHCC website for list of provider organizations: _____) are allowed to get, see, read and copy, and share by and among each other, ALL of your health information (including all of your health information obtained from the RHIO and/or from PSYCKES) that they need to give you care, manage your care or review your care to make health care better for patients. The health information they may get, see, read, copy and share may be from before and after the date you sign this form. Your health records may have information about illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays, blood tests, or screenings), assessment results, and lists of medicines you have taken. Your health records may also have information on:

1. All of my substance use disorder information from all of my alcohol or drug use programs;
2. Family planning services like birth control and abortion;
3. Genetic (inherited) diseases or tests;
4. HIV/AIDS;
5. Mental health conditions;
6. Sexually-transmitted diseases (diseases you can get from having sex);
7. Social needs information (housing, food, clothing, etc..) and/or
8. Assessment results, care plans, or other information you or your treatment provider enters into PSYCKES/the RHIO.

Your health information is private and cannot be given to other people without your permission under New York State and U.S. laws and rules. The providers that can get and see your health information must obey all these laws. They cannot give your information to other people unless you agree or the law says they can give the information to other people. This is true if your health information is on a computer system or on paper. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The providers that use your health information and the BHCC must obey these laws and rules.

Your Consent Choice

☐ I GIVE CONSENT for the _____ BHCC and any of the programs within the BHCC provider organizations as listed on BHCC website to get ALL my health information through the RHIO and/or through PSYCKES to give me care or manage my care, to check if I am in a health plan and what it covers, and to review and make the care of all patients better. I also AGREE that the BHCC and any of the programs within the BHCC provider organizations as listed on BHCC website may share my health information by and among each other. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form and giving it to one of the BHCC participating providers.

☐ I DENY CONSENT for the BHCC to access my health information through the RHIO and/or through PSYCKES and deny consent for the BHCC and its health provider agencies to share my health information with each other.

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Details About Patient Information and the Consent Process

1. **How will BHCC providers use my information?**
   If you consent, BHCC providers will use your health information to:
   • Give you health care and manage your care;
   • Check if you have health insurance and what it pays for; and
   • Review and make health care for patients better.
   The choice you make does NOT let health insurers see your information to decide whether to give you health insurance or pay your bills.

2. **Where does my health information come from?**
   Your health information comes from places and people that gave you health care or health insurance in the past. These may include hospitals, doctors, drugstores, laboratories, health plans (insurance companies), the Medicaid program, and other groups that share health information. You can get a list of all the places and people by calling the BHCC _____ at _____. For a list of the information available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES." For more information about the RHIO visit the _____ website at _____. Your treatment provider may also print out information about these computer systems for you.

3. **What laws and rules cover how my health information can be shared?**
   Laws and regulations include New York Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (which are the rules referred to as "HIPAA").

4. **If I consent, who can get and see my information?**
   The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for a BHCC provider organization and who are involved in your health care and people who work for a BHCC provider who is giving you care to help them check your health insurance or to review and make health care better for all patients. The current list of our BHCC providers can be obtained from the BHCC website at _____.

5. **What if a person uses my information and I didn't agree to let them use it?**
   If you think a person used your information, and you did not agree to give the person your information, call one of the providers you have said can see your records, the BHCC _____ at _____, the United States Attorney's Office at (212) 637-2800, or the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. **How long does my consent last?**
   Your consent will last until: the day you take back your consent or if the BHCC changes its legal status (for example changes to an Independent Practice Association) or three years after the last date of service from a BHCC provider, whichever comes first.

7. **What if I change my mind later and want to take back my consent?**
   You can take back your consent at any time by signing a Withdrawal of Consent Form and giving it to one of the BHCC providers. You can get this form by calling _____. Note: Even if you later decide to take back your consent, providers who already have your information do not have to take it out of their records.

8. **How do I get a copy of this form?**
   You can have a copy of this form after you sign it.

Acknowledgement of Understanding and Signature

I acknowledge and understand the terms of this Patient Information Sharing Consent form. If I have questions about this form, I may contact my health care provider or the BHCC organization. I have been provided and received a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (If Applicable)	Relationship of Legal Representative to Patient (If Applicable)