RMHMO Patient Consent for Release of Personal Health Information Including SUD Treatment Records ("Consent")

Last Name _____ **First Name** _____ **Middle** _____ **Date of Birth** _____

By signing below, I acknowledge that I am enrolled in a health plan offered or administered by Rocky Mountain Health Maintenance Organization, Inc. ("RMHMO") and/or a Medicaid accountable care collaborative that RMHMO participates in as a contractor. I hereby give my consent for _____ (referred to as "Disclosing Organization") to disclose the information described below, which includes alcohol/substance use disorder (SUD) treatment records, to RMHMO for purposes related to payment for services, health care operations, and care coordination activities.

I understand and agree that RMHMO also acts as a coordinated care organization for the purpose of promoting integrated care and patient safety. Therefore, by signing below I also further consent to and give my permission to RMHMO to further disclose my SUD treatment records and information to past, present, and future health care providers with whom I have a treating provider relationship, including care coordination entities that assist RMHMO and other treating providers with care coordination and case management. I understand that I have the right to request a list of my treating providers who have received my substance use disorder treatment information within the past two years because of this consent, and that to request a list of treating providers who have received my information, I may contact RMHMO Customer Service.

Information to be Disclosed: The Disclosing Organization may disclose the following information to RMHMO and my treating providers: all my medical information including a summary of the services and treatment received, diagnosis, prescribed medications, dates of visits, lab tests, claims or encounter data, personal demographic information, treatment plan goals, drug, alcohol, or SUD treatment records and behavioral health records.

Other information about this Consent: I understand that I may take back my permission for my health information to be disclosed under this consent at any time by giving written notice to the Disclosing Organization, except to the extent that the Disclosing Organization or RMHMO has already taken action in reliance on this Consent.

Expiration Date: If it is not revoked, I understand this Consent will expire two years after the date it is signed.

The Patient and/or their Parent/Legal Representative must sign and date this Consent for it to be valid:

_____	_____	
Patient signature [AND/OR]	Date	
_____	_____	_____
Parent/Legal Representative signature (if required)	Date	If not signed by the Patient state the nature of authority, such as Parent, Guardian, or description of other legal authority

☐ OPTIONAL – (You will not receive care coordination services if you check this box, and sign and date below.) By checking this box, and signing and dating below, I choose to "opt- out" of and prevent the disclosure of my information for care coordination purposes as described above. I understand that my information may still be used and disclosed for payment and health care operations. Disclosing Organization must call their RMHMO provider representative to notify RMHMO that consent was not provided for care coordination purposes.

Signature: _____ Date: _____