KAISER PERMANENTE®

AUTHORIZE THE SHARING OF SUBSTANCE USE DISORDER (SUD) MEDICAL INFORMATION

Name: _____

MR#: _____

IMPRINT AREA

Integrating and Coordinating Your Health Care Sharing SUD Medical Information

Kaiser Permanente operates as an integrated health care delivery system. For you to receive the most effective, coordinated care, it is important that members of your care team understand all aspects of your care including treatment for SUD. We will only share the SUD Medical Information that, in the professional opinion of our providers, is necessary to coordinate and integrate your health care as described below.

I understand that my SUD Medical Information records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164, and cannot be disclosed by the Program without my written consent unless otherwise provided for by the regulations.

What We Are Requesting

An authorization for your Kaiser Permanente's Addiction Medicine Department (Program) to share records related to your SUD diagnosis and treatment with your Other Kaiser Permanente Providers - which include medical providers within Southern California Permanente Medical Group (SCPMG), and Kaiser Foundation Hospitals (KFH) to insure your SUD Medical Information is considered as part of your overall medical care you receive within Kaiser Permanente.

Why We Are Requesting this Coordination of Care Authorization

The Program and your Other Kaiser Permanente Providers can best coordinate your overall medical care, if they can work together to prevent negative medication interactions you might experience with the prescribed medications you are taking, or with your treatment programs for other conditions or illnesses.

Ensures you get proper treatment if you visit a Kaiser Permanente Emergency or Urgent Care Department.

Your Protection: Federal laws and Kaiser Permanente's own privacy policies allow us to share necessary information ONLY with Other Kaiser Permanente Providers within the Southern California region and ONLY for the purposes of integrating or coordinating your care. If at any time you have concerns about your privacy, please ask your therapist or a staff member for assistance in care coordination.

The potential consequences (collectively, the "Additional Risks") of declining this Care Coordination Authorization for non-Emergency Medical Care include:

It is possible that dangerous, and even fatal conflicts could occur that would be avoided by integration and coordination of care. The risks of complications in your overall medical care, including chronic pain, chronic disability, disfigurement and death.

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Medical Emergency Waiver
Regardless of whether you consent to the sharing of your SUD Medical Information with Other Kaiser Permanente Providers, your SUD Medical Information may be disclosed to medical personnel to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained.

Revoking Authorization
You or your personal representative may cancel this authorization by submitting a written request to the Release of Information Unit at any Southern California Region Kaiser Permanente Medical Center.

Your cancellation will not affect information that was released prior to receipt of the written request.

Once we receive your revocation, the Program will no longer disclose any SUD Medical Information to Other Kaiser Permanente Providers, except for the information already disclosed during the time when we had your authorization or when the law allows us to disclose the SUD Information without your permission AND you assume the "Additional Risks" described above.

Unless it is revoked, this authorization will remain in effect until you are no longer covered by Kaiser Foundation Health Plan, Inc. Insurance.

Giving Your Authorization is Voluntary: Your decision whether or not to sign this authorization will not affect your eligibility for membership in Kaiser Foundation Health Plan, Inc.

If you choose to sign the refusal statement: You will still be able to access and receive usual care and services from Kaiser Permanente, EXCEPT that you will be assuming the "Additional Risks" as described above AND you are opting out of treatment options and services for your SUD within the Kaiser Permanente's Addiction Medicine Department (Program).

Consent or Refusal to Share Your SUD Medical Information for the purpose of Integrating and Coordinating Your Care.

Please inform Kaiser Permanente staff member either:

☐ I authorize the Sharing of my SUD Medical Information AND indicate your choice of Option 1 (recommended) or Option 2 (limited sharing):

Action Required: Sign Consent to Share SUD Medical Information Form

☐ I refuse to authorize the Sharing of my SUD Medical Information:

Action Required: Sign Refusal to Share SUD Medical Information (understanding your assumed risks and impact on care options within the Kaiser Permanente Addiction Medicine Program)

AND, you will be scheduled to speak with a department representative to discuss the impact of your decision.

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I HEREBY CONSENT TO DISCLOSURE: By the Kaiser Permanente's Addiction Medicine Department (Program) to share my records related to my SUD diagnosis and treatment with my Other Kaiser Permanente Providers - which include medical providers within Southern California Permanente Medical Group (SCPMG), and Kaiser Foundation Hospitals (KFH), to insure my SUD Medical Information is considered as part of the overall medical care I receive within Kaiser Permanente.

I understand that my SUD Medical Information records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164, and cannot be disclosed by the Program without my written consent unless otherwise provided for by the regulations.

The nature and extent of such disclosure shall be as described under Option 1 or Option 2 as I have initialed below:

☐ Option #1 (Recommended) All of my SUD Medical Information which includes:
- All Medications prescribed by the Program
- Diagnoses, patient medical and allergy histories documented by the Program.
- Program Provider progress notes are shared with Other Kaiser Permanente Providers only if the Program Provider determines in their judgment the notes are necessary for coordination of care; the Program progress notes are NOT available without release by the Program.
- Lab, procedure and test results ordered by the Program.
- Secure messages between Other Kaiser Permanente Providers and the Program Providers if in the judgment of the Program Provider the information shared supports integration and coordination of care.

☐ Option #2 (Limited) Our Electronic Medical Record shares some minimal clinical information that we have deemed critical to integrated and quality care.
- All Medications prescribed by the Program
- Diagnoses, patient medical and allergy histories documented by the Program.

This Consent shall terminate upon your written request or if you are no longer covered by Kaiser Foundation Health Plan, Inc. Insurance. I understand that, upon my written request, the Program will provide me with a list of individuals to whom it has disclosed the SUD Medical Information.

If the person receiving care is a minor under 12 years of age, then a parent or legal guardian acknowledges having read and understood this document and authorizes such release. **Both the minor and the parent/legal guardian must sign below**.

Minors over age 12 may consent to treatment and authorize the release of information regarding their treatment themselves without parental permission, in which case only the minor must sign below.

If signed by Parent/Guardian or Personal Representative, Print Parent/Guardian's or Personal Representative's Name and relationship to patient.

PATIENT'S NAME (PRINT)	PATIENT'S SIGNATURE	DATE/TIME
PATIENT'S PARENT/GUARDIAN (PRINT)	RELATIONSHIP	
PATIENT'S PARENT/GUARDIAN SIGNATURE		DATE/TIME
WITNESS (PRINTED)	WITNESS (SIGNATURE)	DATE/TIME
SIGHT TRANSLATED VIA (IF APPLICABLE)	PRINT INTERPRETER'S NAME AND IDENTIFICATIONS NUMBER	
DOCUMENT READ TO PATIENT DUE TO (IF APPLICABLE)	READ BY (STAFF NAME)	

KAISER PERMANENTE®

NOTICE OF FEDERAL CONFIDENTIALITY

Pursuant to 42 CFR § 2.22

Kaiser Permanente's Addiction Medicine Department (Program) is strongly committed to protecting your privacy. State and Federal law protects the confidentiality of SUD Health Records. Such confidentiality is protected under the Federal law and regulations as noted in 42 CFR Part 2.

Violations of the Federal law and regulations by a Program (as noted in 42 CFR) are considered criminal activity. Suspected violations may be reported to the United States Attorney for the judicial district in which the violation occurs.

Central District of California, US Attorney's Office

Office Contact Information
312 North Spring Street
Suite 1200
Los Angeles, California 90012
213-894-2400 (phone)
213-894-0141 (fax)

If at any time you have concerns about your privacy, you are encouraged to request clarification from your therapist or staff member.

Kaiser Permanente's Addiction Medicine Department (Program) staff members are prohibited from disclosing to a person outside the Program that a patient attends the Program or disclosing any information identifying a patient with an SUD diagnosis unless there is a written consent.

Sometimes the law allows us to disclose information about you, without your consent. Examples of such legally permitted disclosures are:

1. In medical and psychiatric emergencies in which information is essential to individual safety;
2. To warn potential victims of violent acts;
3. To qualified personnel for audit, program evaluation of research; for example, patient surveys;
4. For reporting of suspected child abuse or neglect;
5. For information related to a crime committed by you, either at the Program or against any person who works for the Program or any threat to commit a crime; and,
6. In response to court orders that comply with the standards for the type of record covered by law.