Vermont Integrated Communities Care Management Learning Collaborative

[CARE TEAM] RELEASE OF INFORMATION FORM [Subject to Validation by Legal Representative]

Name _____ Date of Birth _____

I WANT MY PROVIDERS TO WORK AS A TEAM

I am choosing a team of supports and service providers to work together on my care. I am a part of this team and I am in charge of my care decisions. I will choose the information my team can share to work on my care.

The providers listed below will be part of my team if I write my initials next to the words "Add this provider." **I can keep seeing my providers even if I do not put them on my team.**

[A] ___ Add this provider
[B] ___ Add this provider
[C] ___ Add this provider
[D] ___ Add this provider
[E] ___ Add this provider
[F] ___ Add this provider

I can also add other providers to my team by listing them here:

_____

_____

_____

_____

HOW MY TEAM WILL USE MY INFORMATION

[My team is allowed to use my private information to help me make a plan for my care. My team will be allowed to share this plan with each other and

give each other updates about my care. Members of my team will also be allowed to use my private information to help me apply for services.]

INFORMATION MY TEAM CAN SHARE

I give the whole team permission to share information that I choose on this form with the other members of the team.

BASIC HEALTH AND SERVICE INFORMATION

I give the providers on my team permission to:

1. Share my [name and date of birth]
2. Say whether I am one of their clients
3. Share my health needs, my goals and my care plan
4. Share information about the services and public assistance I receive
5. Share a list of my income and resources
6. Tell each other when I have appointments and if I miss appointments
7. Give each other updates on my progress
8. [List any other info needed to run the team]

OPTIONAL INFORMATION

I give my team permission to share the information I have selected from the list below. **It can be shared only if I write my initials on the line next to it**.

____[Substance Use]
____[Mental Health]
____[List other sensitive types of information]
____[D]
____[E]
____[F]

I also give my team permission to share the private information that I list here:

_____

_____

_____

__**Check here if this is a replaces an earlier release**

LAWS THAT PROTECT MY PRIVACY

The Privacy Law known as HIPAA protects my health information. Some of the providers on my team may not have to follow this law. These providers will be careful to protect my privacy, but **HIPAA does not protect the records I share with them**.

I know that **my health records could be shared again**. This could include some information about substance use, HIV/AIDS status, and mental health. Information that is shared may no longer by protected under the privacy law known as HIPAA.

I know that **records of substance use or mental health treatment from [Part 2 or Title 18 providers]** are protected by other laws. I know that my team will be told not to share these records with anyone who is not on the team without my written permission.

OTHER WAYS MY INFORMATION CAN BE SHARED

1. I know that there can be times when my team members do not need my permission to share my information.
2. I know that some of my team members may need to report if they find out about **something that is against the law**.
3. I know that some of my team members may need to tell someone if they know that **someone could be in danger**, or if I could be in danger.
4. I know that I can sign **other release forms** to let my team members share my information for other reasons.

I know that I can ask my team members if I have questions or concerns about how my information can be shared.

__**Check here if this is a replaces an earlier release**

HOW TO END OR CHANGE THIS RELEASE

I know that this release will end on its own [if I do not see any of the members on my team for one year.]

I can also set my own end date here: _____

End Date

I can cancel or change this release by contacting:

[Person X]
[Address]
[City], VT [ZIP]
[Phone]

[Person X] will then tell my team that this release has been cancelled. I know that even if I cancel this release, my team members may still have a right to keep and use information that has already been shared.

SIGNATURE

I know this release will only start once I sign and date this page. I know that **if I do not give the team permission to share my information, they will not be able to work together as a team** or share a plan for my care.

I know that **I have a right to keep working with my team members even if I tell them not to share my information.**

I know I have a right to get a copy of this form.

_____ _____

Signed by me or my representative Date

_____

Reason why my representative is allowed to sign for me

_____

Signature of my parent or guardian if I am too young to sign by myself

__**Check here if this is a replaces an earlier release**