NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Health Home Consent Information Sharing For Use with Children Under 18 Years of Age

Instructions: This form must be used for children less than 18 years of age who have been enrolled in a Health Home using *Health Home Consent/Enrollment/ For Use with Children Under 18 Years of Age* (DOH 5200)*. This form outlines what, and with whom, health information can be shared. Section 1 of this form should be completed by the child's parent, guardian, or legally authorized representative. Legally authorized representative for the purpose of sharing health information is defined as "a person or agency authorized by state, tribal, military or other applicable law, court order or consent to act on behalf of a person for the release of medical information". Section 2 of this form is completed separately by the child with the care manager.

***[Please note, children who are parents, pregnant, and/or married, and who are otherwise capable of consenting, should not use this form. Rather, they must use the** *Health Home Patient Information Sharing Consent* **form (DOH 5055)].**

Care Design NY
PRINT NAME OF HEALTH HOME

Sarah J. Master
PRINT NAME OF CHILD

1/28/2002
CHILD'S DATE OF BIRTH

Section 1:

Instructions for Parent/Guardian/Legally Authorized Representative: List all of the child's health providers who can share the child's health information. The health information they share may be from before and after the date you sign this form. These providers can share this information with each other and with the child's care management agency listed below. They cannot give the child's information to other people unless you agree or the law says they can. The child can keep private any information about services that the child consented for, including family planning and emergency contraception, abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services. Providers of these services will be listed in Section 2. If you consented for these services for the child, then you may have the authority to consent to the release of information regarding these services and can list the providers in this Section. Note: the child may have to consent to the release of this information also.

Instructions for Care Manager: This section is completed by the child's parent, guardian, or legally authorized representative. It lists all health providers who can share the child's health information. List the child's care management agency as a provider below. These providers can share all health information except for any information about services the child consented for, including family planning and emergency contraception, abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services. If the parent, guardian or legally authorized representative consented to abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, or drug and alcohol treatment on behalf of the child, information can only be released if the child also consents to the release in Section 2. Copy this page as needed to be able to list all agreed to providers. If this list needs to be updated in the future (to either add or remove a name), please have the parent/guardian/legally authorized representative initial and date next to each new entry or omission.

Instructions for Participating Provider: If your name or agency is listed in Section 1, you may release the child's health information except for any information about services the child consented for, including family planning and emergency contraception, abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, prenatal care, labor and delivery services, drug and alcohol treatment, or sexual assault services. You may only release this information if you are given permission to do so in Section 2 of this form. If the parent, guardian or legally authorized representative consented to abortion, sexually transmitted infection testing and treatment, HIV testing and treatment, HIV prevention, or drug and alcohol treatment on behalf of the child, information can only be released if the child also consents to the release in Section 2.

	PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE INITIALS (ONLY INITIAL WHEN CHANGES MADE TO THE LIST OF PROVIDERS BELOW)	DATE
Care Design NY CARE MANAGEMENT AGENCY	A.M.	4/19/2018
NAME OF PROVIDER		
NAME OF PROVIDER		
NAME OF PROVIDER		
NAME OF /PROVIDER		
NAME OF /PROVIDER		
NAME OF PROVIDER		
NAME OF PROVIDER		
NAME OF PROVIDER		
NAME OF PROVIDER		

By signing this form, I agree that:

1. The child listed above is enrolled in the Health Home listed above,
2. I have signed a consent for enrollment form with the Health Home indicated above for the child listed above,
3. I have had the chance to review the Health Home FAQ sheet and have had my questions answered,
4. The Health Home and anyone I have named in Section 1 of this form can share Sarah J. Master health information, as outlined in the instructions above, with each other. They may share information from before and after the date I sign this form, and

NAME OF CHILD

5. The child's Health Home and Managed Care Plan, if applicable, can share information with those listed as providers above and with each other.

I can change this form at any time. If I make changes, I have to initial and date next to those changes. By crossing out information, I am taking away permission to share the health information that I previously allowed.

I understand that this consent form takes the place of other Health Home information sharing consent forms I may have signed before on behalf of the child. This consent stays in place until:

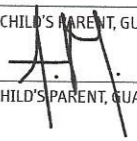
- I withdraw it , or
- The child is no longer eligible for a Health Home.
- The Health Home is no longer in business.

I can always take back this consent on behalf of the child by signing a *Health Home Consent/Withdrawal of Health Home Enrollment and Information Sharing/For Use with Children Under 18 Years* form (DOH 5202).

If I do not sign this consent form, I understand that the child's information will not be shared.

Aaron S. Master

PRINT NAME OF CHILD'S PARENT, GUARDIAN OR LEGALLY AUTHORIZED REPRESENTATIVE



SIGNATURE OF CHILD'S PARENT, GUARDIAN OR LEGALLY AUTHORIZED REPRESENTATIVE

Father

RELATIONSHIP OF PARENT, GUARDIAN OR LEGALLY AUTHORIZED REPRESENTATIVE TO CHILD

4/19/2018

DATE

TO BE COMPLETED WITH CHILD ONLY

Section 2:

Instructions for Care Manager: Section 2 of this form should be completed by the child. Completion of this form should be done in private, without the child's parent, guardian, or legally authorized representative, to allow for confidentiality of the information. Section 2 of this form should be completed after Section 1 has been completed and signed by all necessary parties.

I, Sarah J. Master, **understand that I can consent for certain types of health care services without my parent, guardian, or legally authorized representative knowing. I can also decide who is allowed to share information about these services. For the services below (which I may have had in the past), I am initialing to give the following Provider permission to share information regarding that care.**

NAME OF CHILD

Types of Services and Name(s) of Provider and/or Agency	It is okay to share information about these services with my **parent, guardian or legally authorized representative** named below.		
	Yes	**No**	Name of **parent, guardian, or legally authorized representative**
Family Planning Provider(s):	☐	☐	
Emergency Contraception Provider(s):	☐	☐	
Abortion Provider(s):	☐	☐	
HIV Testing and Treatment Provider(s):	☐	☐	
HIV Prevention Pre-exposure and Post-exposure Prophylaxis (PrEP/PEP) Provider(s):	☐	☐	
Sexually Transmitted Infection Testing and Treatment Provider(s):	☐	☐	
Prenatal Care, Labor/Delivery Provider(s):	☐	☐	
Drug and Alcohol Treatment Provider(s):	☐	☐	
Sexual Assault Services Provider(s):	☐	☐	

If you are receiving mental health and/or developmental disabilities services, and are over the age of twelve, your provider may ask you if you want your information disclosed. If you object, your provider may: deny the request entirely, send only part of the record, or send a summary of your clinical record.

Types of Services and Name(s) of Provider and/or Agency	It is okay to share information about these services with my **parent, guardian or legally authorized representative named below.**		
	Yes	**No**	Name of **parent, guardian, or legally authorized representative**
Mental Health Services:	☐	☐	
Developmental Disabilities Services:	☐	☐	

Types of Services and Name(s) of Provider and/or Agency	It is okay to share information about these services with the **providers** listed below.		
	Yes	No	Name of **provider**
Family Planning Provider(s):	☐	☐	
Emergency Contraception Provider(s):	☐	☐	
Abortion Provider(s):	☐	☐	
HIV Testing and Treatment Provider(s):	☐	☐	
HIV Prevention Pre-exposure and Post-exposure Prophylaxis (PrEP/PEP) Provider(s):	☐	☐	
Sexually Transmitted Infection Testing and Treatment Provider(s):	☐	☐	
Prenatal Care, Labor/Delivery Provider(s):	☐	☐	
Drug and Alcohol Treatment Provider(s):	☐	☐	
Sexual Assault Services Provider(s):	☐	☐	

If you are receiving mental health and/or developmental disabilities services, and are over the age of twelve, your provider may ask you if you want your information disclosed. If you object, your provider may: deny the request entirely, send only part of the record or send a summary of your clinical record.

Types of Services and Name(s) of Provider and/or Agency	It is okay to share information about these services with the **providers** listed below.		
	Yes	No	Name of **provider**
Mental Health Services:	☐	☐	
Developmental Disabilities Services:	☐	☐	

By signing this form, I agree that:

1. I have had the chance to review the Health Home FAQ sheet and have had my questions answered, and
2. The Health Home and anyone I have named in Section 2 of this form can share my health information as listed above. They may share information from before and after the date I sign this form.

I can change this form at any time. If I make changes, I have to initial and date next to those changes. By crossing out information, I am taking away permission to share the health information that I previously allowed.

I understand that this consent form takes the place of other Health Home information sharing consent forms I may have signed before. This consent stays in place until:

- I withdraw it,
- I am no longer eligible for a Health Home,
- The Health Home is no longer in business, or
- My parent, guardian or legally authorized representative signs a *Health Home Consent/Withdrawal of Health Home Enrollment and Information Sharing/For Use with Children Under 18 Years of Age* form (DOH 5202).

PRINT NAME OF CHILD _____ CHILD'S DATE OF BIRTH _____

SIGNATURE OF CHILD _____ DATE _____

☐ By checking this box, I am withdrawing my consent to share my health information listed in Section 2.

PRINT NAME OF CHILD _____ CHILD'S DATE OF BIRTH _____

SIGNATURE OF CHILD _____ DATE _____