AUTHORIZATION TO SHARE CONFIDENTIAL MEMBER INFORMATION (ASCMI) FORM: AB 133[1] (VERSION 2.0)

First Name	Middle Name	Last Name	Date of Birth	Medi-Cal Client Index Number (as applicable)

The "ASCMI Form: AB 133" can be used to authorize data sharing for the following individuals:

1. Individuals enrolled in a Medi-Cal managed care plan.
2. Individuals receiving behavioral health services under Medi-Cal.
3. Individuals involved in the criminal legal system that qualify for pre-release Medi-Cal benefits.

Medi-Cal wants to help coordinate your health and social services so that you can live a healthier life. The care and services you get through Medi-Cal are provided by multiple organizations. Your Care Partner may ask you to sign the Form when they need your consent to share your information with other people or organizations you are receiving care or services from. The Form is not intended to authorize the general release of your information when not required for coordinating your care. Please see below for further details on the purpose of information sharing and who can share and receive your information.

This ASCMI Form will:

- Explain what information about you may be shared to help coordinate your care.
- Explain how your information may be shared and used.
- Ask for your permission to share certain types of your information. The types of information are listed in Section 1.3 of the ASCMI Form.

[1] AB 133 refers to California Assembly Bill 133.

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Member Information

Member Name: _____ Date of Birth (mm/dd/yyyy): _____

Medi-Cal Client Index Number (as applicable)[2]: _____

Mailing Address, City/State, Zip Code[3]: _____

Residential Address, City/State, Zip Code (optional): _____

Phone Number (optional): _____ E-mail Address (optional): _____

Do you give permission for your Care Partners to contact you via text or phone call? Your Care Partner may contact you to talk about your consent choices and to let you know if your consent has expired.[4] Please check the box with your choice below:

◯ Yes (Must provide phone number above)

◯ Text and phone call ◯ Text only ◯ Phone call only

◯ No

Care Partner Information

This should be completed by the Care Partner obtaining consent from the Member above to disclose their information.

Care Partner Name: _____

Organization Name: _____

National Provider Identifier (NPI) Number (as applicable): _____

Taxpayer Identification Number (TIN): _____

Phone Number: _____ Fax Number (optional): _____

Mailing Address, City/State, Zip Code: _____

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[2] The Client Index Number is the first nine characters of the identification number located on the front of the Medi-Cal Member's Benefits Identification Card.

[3] This can be any address where you can receive mail, including the address of a friend, shelter, or family member.

[4] This may result in charges to your cell phone.

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Section 1: Overview of Sharing Your Personal Information

1.1 Purpose of Information-Sharing

Your personal information listed in Section 1.3 below may be shared for many reasons, including:

- Coordinating your care. For example, helping you schedule an appointment, helping you request housing support, or helping you find a provider.
- Providing you with medical, dental, mental health, and substance use disorder treatment and services.
- Obtaining payment from your health insurance carrier for the treatment and services provided to you.
- Connecting you to programs, services, and resources that can help improve your health and wellbeing.
- Collecting information so that Medi-Cal can help improve the care you are receiving.

1.2 Who Can Share and Receive Your Information

Care Partners may share and receive your information. Care Partners are providers and organizations you have seen before, are seeing now, or may see in the future. These Care Partners include:

- Health care providers, including primary care physicians and mental health specialists.
- Substance use disorder providers, such as opioid treatment programs and residential treatment programs.
- Community-based organizations and homeless service providers.
- Correctional facility providers and case managers.
- Health insurance plans, including Medi-Cal managed care plans and behavioral health plans.
- County health and human services agencies.
- Qualified health information organizations.
- State health and human services agencies.

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1.3 Types of Information

What types of information require your consent to share?

There are some types of information that you can choose to share or choose not to share:

- Substance use disorder information that is protected by 42 C.F.R. Part 2.
- Housing information, including your housing status, history, and housing supports.

More details about these types of information can be found in Section 2.1 of this Form. You can choose whether or not to give your consent to share these types of information. When you give your consent, that means you are giving your permission to share this information.

Some of your Care Partners can use and share some of your health and social services information with other Care Partners, without your consent, to:

- Treat you.
- Obtain payment for services.
- Operate their organization and coordinate your care.

What types of information may be shared without your consent?

- Medical and mental health information.
- Substance use disorder information that is not protected by federal law 42 C.F.R. Part 2.
- Health insurance information.
- Limited criminal legal information, including booking data, dates and location of incarceration, and parole status.

If you are incarcerated, or were recently incarcerated, your care partners can share some criminal legal information described above. They can share that information to help you apply for health insurance and connect you with mental health and substance use disorder services. The information cannot be used for civil, administrative, or criminal investigations, proceedings, or prosecutions, sentencing, immigration enforcement, or family court proceedings.

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Section 2: Request for Your Permission

2.1 Special Permissions

There are two special permissions requested from you:

1. Substance Use Disorder Information
2. Housing-Related Personal Information

Select "Yes" or "No / Does not apply to me" for each special permission

Selecting "Yes" or "No / Does not apply to me" is your choice. Even if you select "No / Does not apply to me" on the Form, it will not change your eligibility for benefits or ability to receive health care or services.

- » If you select **"No / Does not apply to me"** on the Form, your Care Partners will not share the information for which you selected "No / Does not apply to me."
  - If you choose not to sign the Form, your Care Partners will not share the information described in this section.
- » If you select **"Yes"** on the Form, your Care Partners can share important information about you that will help them coordinate your care. It will also help them to connect you more easily to other services.

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1. Substance Use Disorder Information

- Some substance use information is protected by the federal law 42 C.F.R. Part 2, commonly referred to as "Part 2." Your Care Partner treating your substance disorder can tell you if your substance use disorder information is protected by 42 C.F.R. Part 2.
- You can give your permission to share Part 2 substance use diagnosis or treatment information so that providers can treat you, obtain payment for services, operate their organization, and coordinate your care.
- When you give permission to share your Part 2 substance use information with Medi-Cal, your health plan, or another health care provider, they are allowed to share that information with other Care Partners for the same purposes stated in the bullet above. They may also share your information without your consent for other purposes that are allowed under federal and state law. They cannot share this information for civil, criminal, administrative, and legislative proceedings against you.
- Once your Part 2 substance use information has been used or shared, it may no longer be protected by Part 2 or protected in the same way it was before it was used or shared. Your Part 2 substance use information may instead be protected by other laws that protect your health information.
- You can get a list of the Care Partners that your Part 2 substance use disorder provider has shared your information with by contacting your substance use disorder provider.

Your Consent: I give permission for my substance use disorder treatment providers to share my past, present, and future substance use disorder information, including information that is protected by Part 2.

◯ Yes ◯ No / Does not apply to me

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2. Housing-Related Personal Information

If you need housing services, you may be able to get help through Coordinated Entry. Coordinated Entry are local organizations that help coordinate housing services for people who need them. These organizations may need your permission to share your housing-related information with Homeless Management Information Systems and other Care Partners, such as your health care provider. These systems are used by housing organizations to provide and coordinate housing and housing support services.

Your Consent: I give my permission for my local housing provider to share personal information about me related to housing including my housing status, history, and supports with its Homeless Management Information System and other Care Partners, such as my health care provider.

◯ Yes ◯ No / Does not apply to me

2.2 Your Rights

What are your rights?

You have the right to:

- Sign this Form.
- Not sign this Form.
- Receive a copy of this Form.
- Change your mind and take back your permission.

If you sign this Form, can you change your mind later?

Yes, you have the right to change your mind about sharing your information, and you may change or take back this consent at any time. To change or take back your consent, talk with your Care Partners. You will have to complete a new ASCMI Form with the changes you want to make.

- Any changes you want to make will happen on the day your new ASCMI Form is signed.
- Taking back your consent will not apply to information that was previously shared with your consent.

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2.3 Your Signature

By signing this Form, you understand and agree that:

- Your Care Partners, listed in Section 1.2 of this Form, may use and share the health and personal information you selected above for purposes described in Section 1.1 of this Form.
- You also understand that when your information is shared, federal or state law may not protect the re-sharing of that information.

How long does your consent to share your information last?

- **If you are 18 or older**, this consent will last for one year from the date you signed the form.
- **If you are under age 18,** your consent will last for one year from the date you signed the Form. If you turn 18, or if your guardianship changes, during this one-year period, you will need to provide new consent.
- Regardless of your age, you will need to provide new consent using the ASCMI Form: Non-AB 133 if you no longer meet the criteria to use the ASCMI Form: AB 133. You can also change your mind and take back your consent at any time in writing using the ASCMI Revocation Form.

Member Name	Member Signature	Date (mm/dd/yyyy)
Parent/Guardian/Legal Representative Name	Parent/Guardian/Legal Representative Signature	Date (mm/dd/yyyy)

Translations for this document are available on the DHCS website Language translations