AUTHORIZATION TO SHARE CONFIDENTIAL MEMBER INFORMATION (ASCMI) FORM: NON-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: Non-AB 133" can be used to authorize data sharing for individuals residing in California who do not meet the criteria to use the ASCMI Form: AB 133. This includes all individuals that are:

1. Not enrolled in a Medi-Cal managed care plan.
2. Not receiving behavioral health services under Medi-Cal.
3. Not involved in the criminal legal system that qualify for pre-release Medi-Cal benefits.

_____ wants to help coordinate your health and social services so that you can live a healthier life. 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 detail 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

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Client Information

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

Mailing Address, City/State, Zip Code[2]: _____

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.[3] 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 Client 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: _____

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

[3] 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 therapist.
- Providing you with medical, dental, mental health, and substance use disorder treatment and services.
- Obtaining payment from your 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 _____ can help improve the care you are receiving.

1.2 Who Can Share and Receive Your Information

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

- Health care providers, including primary care providers and mental health providers.
- Substance use disorder providers, such as opioid treatment programs and residential treatment programs.
- Community-based organizations and homeless service providers.
- 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.
- Some mental health information.
- Intellectual and developmental disability information.
- HIV test results.
- Genetic test results.
- Housing information, including your housing status, history, and supports.

More information about each type of information listed above 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 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 (see exceptions below).
- Substance use disorder information that is not protected by federal law 42 C.F.R. Part 2.
- Health insurance information.

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Section 2: Request for Your Permission

2.1 Special Permissions

There are six special permissions requested from you:

1. Substance Use Disorder Information
2. Housing-Related Personal Information
3. Mental Health Information
4. Intellectual and Developmental Disability Information
5. HIV Test Results
6. Genetic Test Results

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" 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" or "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 providers.

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

3. Mental Health Information

Your consent is required to share some of your mental health information. This includes information about mental health care you may have received from providers in your community, such as treatment records, prescription details, or assessments. It may also include mental health information if you received care in a state or county hospital or mental institution, or while you were in jail.

Your Consent: I give permission for my Care Partners to share my mental health information.

◯ Yes ◯ No / Does not apply to me

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4. Intellectual and Developmental Disability Information

- Your consent is required to share certain information regarding your intellectual and developmental disabilities. These are conditions that affect how a person's brain and body work. They usually start before the age of 22 and last throughout life. Intellectual disabilities can make learning, problem-solving, and daily tasks more challenging. Developmental disabilities are a broader group that can affect physical abilities, thinking, language, and behavior. Examples of intellectual and developmental disabilities include autism, Down syndrome, cerebral palsy, and epilepsy.
- People with these disabilities sometimes need more support in life, but that doesn't change a person's value, skills, or contributions to their communities. Everybody is unique and has different skills and needs. Sharing information about your intellectual and developmental disability between different agencies can mean that all your support people know more about how to help you.

Your Consent: I give permission for my Care Partners to share my intellectual and developmental disability information.

◯ Yes ◯ No / Does not apply to me

5. HIV Test Results

Your consent is required to share any HIV test results that you may have received with another Care Partner that is not directly providing you with HIV-related care.

Your Consent: I give permission for my Care Partners to share my HIV test results.

◯ Yes ◯ No / Does not apply to me

6. Genetic Test Results

Your consent is required for your health insurance plan, including Medi-Cal, to share the results of any genetic tests you may have received. Genetic test results are lab tests that are used to identify certain genetic diseases or health conditions that you may have.

Your Consent: I give permission for my Care Partners to share my genetic test results.

◯ Yes ◯ No / Does not apply to me

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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 can 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 affect 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 age 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 can change your mind and take back your consent at any time in writing using the ASCMI Revocation Form.

Your Name	Your 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