NEW YORK STATE DEPARTMENT OF HEALTH
Medicaid

Health Home Patient Information Sharing Withdrawal of Consent

_____
Name of Health Home Provider Organization

By signing this form I am saying that I do not want to be in the _____ Health Home program.
Name of Health Home

Because I will no longer be in this Health Home program, by signing this form I am also taking away my permission for the Health Home to share my personal health information with providers and others in the Health Home program, including the Regional Health Information Organization (RHIO) and/or the Office of Mental Health's (OMH) PSYCKES and/or the Office for People With Developmental Disabilities' TABS/CHOICES computer system. If I signed a separate consent form with the RHIO and/or PSYCKES and/or TABS/CHOICES, my permission to share my personal health information with providers and others through the RHIO and/or PSYCKES and/or TABS/CHOICES will continue. I understand that the providers who already have my health information do not have to give it back to me or take it out of their records. But, Health Home providers may no longer get, see, read, copy and share my health information after the date I sign this form. I know that "personal health information" may include health, mental health, developmental disability, alcohol or substance abuse treatment, and/or HIV/AIDS information.

I am aware that my personal health information will still be protected under New York State and U.S. laws and rules. The Health Home partners that currently have my health information must obey all of these laws.

I also am aware that ending my participation in the Health Home program will not prevent me from getting health care or other direct care management services.

Any previously signed Health Home Consent Forms signed by me are hereby revoked.

Print Name of Patient	Patient Date of Birth
Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about Patient Information and the Withdrawal of Consent Process

1. **How will partners further use my information?**
   Partners may no longer use your health information.
2. **What will happen to my health information?**
   Your health information will be kept by providers who already have your information, but still must protect it by following all New York State and U.S. laws and rules.
3. **What laws and rules cover how my health information can be shared?**
   These laws and regulations are New York Education Law Section 6530(23), Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 CFR Parts 160 and 164 and the federal confidentiality regulations in 42 CFR Part 2.
4. **Who can get and see my information after I withdraw my consent?**
   No one can obtain any new health information about you, but information that has already been disclosed cannot be taken back. People who can see health information already disclosed are: those that were part of the Health Home before you withdrew consent, like doctors and other people who work for a Health Home partner and who were involved in your health care; health care providers who are working for a Health Home partner who gave you care; and people who work for a Health Home partner who gave you care to help them check your health insurance or to study and make health care better for all patients. Also, when you got care from a person who was not your usual doctor or provider, like a new drugstore, new hospital, or other provider, some information, like what your health plan pays for or the name of your Health Home provider may have been given to them or seen by them.
5. **What if a person uses my information and I didn't agree to let them use it?**
   If this happens, you can:
   - call the Medicaid Helpline at 1-800-541-2831, or
   - contact the US Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019, or submit a written complaint at: https://www.hhs.gov/hipaa/filing-a-complaint/index.html

   You may also want to:
   - call one of the providers you have said can see your records,
   - call your care manager or health home: _____ at _____, or
   - call your Managed Care Plan if you belong to a Managed Care Plan.

6 **How long does my withdrawal of consent last?**
Your withdrawal of consent will last until the day you sign a new consent to a Health Home.

7. **What if I change my mind later and want to participate in a Health Home and have my health information shared?**
If you change your mind please let your health plan or former Health Home know that you are interested in being in a Health Home again.

8. **How do I get a copy of this form?**
After you sign this Withdrawal of Consent Form, ask for a copy and it will be provided to you.