Alameda County
Health Care Services Agency

Instruction for collecting and submitting Information Sharing Authorization (ISA) to Alameda County Health Care Services Agency

1. Open your browser and go to the URL: http://accareconnect.org/information-sharing-authorization/

2. Scroll to the Information Sharing Authorization section of the web page.

3. Download PDF-formatted ISA document in the language appropriate for your client / patient / consumer (available options are English, Spanish, Chinese, Vietnamese, Punjabi and Tagalog).

4. Open the fillable PDF document in Adobe Acrobat. (*Note: If you do not have Adobe Acrobat please download from the URL*: https://get.adobe.com/reader/. ***You may need to request your IT team to help if you do not have permission to download and install new software***.)

5. Enter Client Name, Date of Birth and Medi-Cal ID (CIN), if known.

6. If the client authorizes a representative to sign on their behalf, please add his or her full name and their relationship to the client at the bottom of the ISA.

7. Scroll down to Page 4 of the ISA to enter your client's choice for sharing Mental Health treatment and HIV test results for the purpose of care coordination.

8. At this time, to save an electronic copy of this ISA you will need to save the file with the appropriate name on your local directory or your network folder. If you do not want to save a copy press the print button on the Acrobat window.

9. Print the document and have your client or the authorized representative sign and date the ISA (only current date is allowed). [*Note*: *you can also add the date electronically before printing the ISA*]

10. The ISA is now ready to send to the Alameda County Health Care Services Agency. **Please add a cover letter with your name, phone number, email and your organization or facility's name and fax the form to (510) 244-0596.**

11. **Do not modify, alter or change the content or structure of the ISA form. Any submissions of ISA forms with modifications, changes or alterations will not be accepted.**

12. Clients can revoke their authorizations at any time by sending a letter, email or filling out page 5 of this form. If the last method is used for revocation, do not fax the form. Instead upload the scanned copy of the page 5 to the CHR.

Alameda County Information Sharing Authorization

Authorization for Sharing Your Protected Health and Personal Information

Client Name: ___________________________________ Date of Birth: _________

Medi-Cal CIN (If known): ________________

The County of Alameda (the "County") is asking for your authorization to allow sharing of your protected health information and other personal information ("information"). If you agree, your information will be shared with (to and from) the County and the following types of organizations to help coordinate your care, resources, and human services.

- Physical and mental health providers
- Health plans
- Jail Health Services providers
- Crisis response providers
- Social Services Agency
- Housing support
- Community services, for example, foodbanks, public libraries, legal services

Your information from the types of organizations above will also be shared with Substance Use Disorder (SUD) providers. SUD providers can only receive it to help coordinate your care, resources and human services. Note: This authorization does not allow SUD Providers to share your SUD information.

Sharing information makes it easier to see if you are eligible for resources. It also allows you to get services and take part in programs run by the County and other organizations in Alameda County to improve your health ("services" and "programs"). This includes programs and services like Alameda County Care Connect (Care Connect), Healthcare for the Homeless, and Everyone Home.

Signing this Authorization Form ("Form") is your choice. No matter what you choose, it will not change your ability to receive medical services, treatment or public human services.

By signing this Form, you are authorizing your information to be shared with (to and from) the County and the types of organizations shown above. It will be used to see if you are eligible for other resources, help link you to them, and help coordinate between them to better serve you.

If you do not sign this Form, you can still receive medical services, treatment, or public human services. Not signing may keep you from being able to fully take part in certain programs within the County for coordinating your care.

How will sharing benefit me?

If you allow your information to be shared, those serving you will be able to:

- Identify and connect you to programs, services or resources that could benefit your health and wellbeing.
- Better coordinate your care.
- Improve the quality of services.
- Conduct other program work within the County.

How will it be shared?

Your information will be shared in electronic formats using a community health record. This is a type of computer program that allows organizations to share information to improve people's health. Your information will also be shared in verbal and written formats.

Who will be sharing my information?

Your information will be shared with (to and from) the County and the types of organizations shown above. Your information from the types of organizations above will also be shared with SUD providers. Organizations may include the people who staff County referral or advice call lines. They may also include organizations involved in your care now, in the past and in the future. A list of current organizations will be printed for you. It can also be accessed at www.accareconnect.org/organizations.

The person or organization with whom your information has been shared may be able to use or disclose your information without being subject to privacy law.

Can I find out who my information is shared with?

You have the right to request a list of the organizations that have accessed your information using this Form. To make such a request, call the Alameda County Social

Health Information Exchange Help Desk ("Help Desk") at (510) 618-1997.

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What will be shared?

Information will be shared about programs and services you got in the past, get now, and in the future. This includes data about:

- Physical and mental health conditions.
- Housing, human or legal needs.

Substance Use Disorder (SUD) information protected by Federal law 42 C.F.R. Part 2 is not included as part of this authorization.

Information shared may include details such as:

- Your name, address, date of birth, etc.
- The status of your medical or mental health, and treatments.
- Your housing, food, transportation, employment, income, and disability needs.
- The support you get through the County Social Services Agency like Medi-Cal, CalFresh, General Assistance, CALWORKs, Supplemental Security Income.

What is still shared if I don't sign?

State and Federal laws already allow for some sharing of information. For example, health care organizations can share your health information to treat you, obtain payment, and run their programs. Signing this Form does not change what can be shared under these laws.

Can I limit what gets shared?

You may limit sharing of mental health treatment and HIV test results information in the special permission section.

If I sign, can I change my mind later?

You have the right to change your mind about sharing and revoke this authorization at any time. This Form is valid until the date that you cancel or change it in writing.

- To cancel or make a change, talk with your Care Team Member. You can complete a new Form to

- reflect the change(s). Any changes will take effect as of the date the new Form is signed.
- Any data or information shared before that time cannot be recalled.

Required Section We need your special permission to share information about mental health treatment and HIV test results.

If you give permission, your mental health treatment and HIV test result information will be shared with (to and from) the County and the types of organizations listed above to help coordinate your care, resources, and human services. Even if these do not apply to you today, giving permission can help make sure your information can be shared in the future if needed.

Mental health treatment

I give permission to share information about my past, present and future mental health treatment. (Psychotherapy notes will not be shared.)

□ Yes □ No

HIV test results

I give permission to share information about my past, present and future HIV test results.

□ Yes □ No

I have the right to:

- Refuse to sign this Form.
- Receive a copy of this Form.

By signing this Form I agree that:

- I have read this Form or an Alameda County Representative or Care Team Member has read it to me.
- I understand it.
- I give authorization for my information to be shared as described above.
- This authorization will remain in effect for a period of 1 year, or until I change or revoke my authorization in writing. I can do this by contacting my Care Team Member.

____ __________________________

Client Signature | Date

If signed by a person other than the client, please write that person's relationship to the client:

__________________________________ __________________________________

Relationship to Client | Personal Representative's Name

Alameda County
Health Care Services Agency

Revocation of Information Sharing Authorization

Client Name: ____ Date of Birth: __________

Medi-Cal CIN (If known): __________________

I wish to revoke my authorization. (Please send to your Care Team member)

Signature of Client or Client's Legal Representative:

____ ________/________/________
Month *Day* *Year*

If signed by Client's Legal Representative, state relationship and authority to do so:

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