Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

CONSENT FOR RELEASE OF MEMBER INFORMATION INSTRUCTIONS

It is the policy of Trillium Health Resources to obtain the enrollee's consent (whenever possible) prior to disclosing protected health information. If you need to request an enrollee's medical records print this form, fill it out, and mail to Trillium Records Management at 144 Community College Rd, Ahoskie, NC 27910 or fax it to 252.209.6084.

Important Notes:

1. Requests for psychotherapy notes cannot be combined with requests for any other type of protected health information. A separate form requesting the remaining records will need to be sent.
2. Requests for records created by providers who are currently practicing in North Carolina must be secured from that provider.
3. Trillium maintains limited historical Member records from the following

   Closed agencies:
   - Albemarle Mental Health Center
   - CoastalCare
   - East Carolina Behavioral Health (ECBH)
   - EastPointe Human Services
   - Neuse Mental Health Center
   - Onslow Carteret Behavioral Health (OCBH)
   - Pitt Mental Health Center
   - Roanoke /Chowan Human Services Center
   - Sandhills Center
   - Southeastern Center for Mental Health, Developmental Disabilities and Substance Abuse Services
   - Tideland Mental Health Center
4. Trillium also maintains limited member records from Providers who no longer practice in North Carolina.
5. If the records contain information pertaining to substance use or alcohol treatment, re-disclosure of these records is STRICTLY PROHIBITED without written consent from the member.

Instructions for Completing the Authorization Form

Complete the blanks as follows:

1. Provide the enrollee's full name, maiden name or other previous names, date of birth, and a social security number if available.
2. If the member is present and requesting the records to be sent to your office, have them print their name in the following statement: "I, _____hereby request and authorize…" If you, as the Provider, are requesting the records, print the name of the practice and your name in the same statement.
3. Enter the name of the organization/facility/person where the records are coming from. (Examples: Southeastern Center, Roanoke/Chowan Human Services Center etc.)
4. Enter the name of the organization/facility/person you want the records sent to. Provide the full address and fax number.
5. Indicate specifically which records you want to have sent. (Examples: most current medication list, last psychological evaluation, CCA)
6. State the purpose for the disclosure. (Example: Care and Treatment)
7. Indicate when the request will expire. This is most often one year from date of signing.
8. Sign and date it. If you are not the member, please indicate your relationship to the member and present supplemental documentation. (Examples: Provider, Healthcare Power of Attorney, Custodial papers if you are the legal guardian, or notarized statement as a *person standing in loco parentis.)*

If you have questions, please call 1-866-998-2597 for assistance.

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CONSENT FOR RELEASE OF MEMBER INFORMATION

Member Name _____ Member Record # _____

Member DOB _____ Member Social Security Number: (Optional) _____

This authorization form implements the requirements for member authorization to use and disclose health information protected by:

- Federal Health Privacy Law, 45 CFR Parts 160, 164
- Federal Drug and Alcohol Confidentiality Law, 42 CFR, Part 2
- North Carolina State Confidentiality Law governing mental health, developmental disabilities, and substance abuse services, NC GS § 122C.

I, _____ hereby request and authorize, **Trillium Health Resources,** to release/receive specified health information from the records of above named member to/from:

For the specific purpose(s) of:

The data to be released/received may include the following protected information: (please specify)

- ☐ History and Physical
- ☐ Screening Assessment
- ☐ Current Medications
- ☐ Insurance Benefits/Claims
- ☐ Lab Work
- ☐ Psychiatric Evaluation
- ☐ Discharge Summary
- ☐ Service Plan/Treatment Plan
- ☐ Psychological/Psycho-Ed
- ☐ Progress Notes
- ☐ Diagnoses
- ☐ Other

Specify

Non-English Speakers
If English is not the member's primary language, it is the provider's responsibility to make interpretive services available to the member at no cost. That responsibility includes having someone interpret and explain this release of information to the member. Please contact Trillium Health Resources at 1-877-685-2415 if you have questions.

I understand that this authorization will expire on the following date, event or condition:

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I UNDERSTAND THAT IF MY RECORD CONTAINS INFORMATION RELATING TO HIV INFECTION, AIDS OR AIDS-RELATED CONDITIONS, ALCOHOL ABUSE, DRUG ABUSE, PSYCHOLOGICAL OR PSYCHIATRIC CONDITIONS, OR GENETIC TESTING, THIS DISCLOSURE WILL INCLUDE THAT INFORMATION.

I understand that my information may not be protected from re-disclosure by the requestor of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

SIGNATURES

Signature of member	*Date*	*Witness-If Required*

Signature of Personal Representative	*Date*	*Personal Representative Relationship/Authority*

REVOCATION SECTION

ONLY fill out this section when you no longer want Trillium to release your records.

I do hereby request that this authorization to disclose health information of

_____
(Name of member)

signed by_____ on _____
(Enter Name of Person Who Signed Authorization) (Enter Date of Signature)

be rescinded, effective _____(date). I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

_____	_____	_____	_____
Signature of member	*Date*	*Signature of Witness*	*Date*
_____	_____	_____	_____
Signature of Personal Representative	*Date*	*Personal Representative Relationship/Authority*	*Date*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by

_____

on _____(date). The Member or his personal representative has been informed that any action taken on this authorization prior to the rescinded date is legal and binding.

_____	_____	_____	_____
Signature of Staff	*Date*	*Signature of Witness*	*Date*

NOTE: This Authorization was revoked on: _____ _____
Date *Signature of Staff*