Patient Consent and Authorization Form for Disclosure of Substance Use Disorder Health Information to Medicaid

Member (name and information of member whose health information is being disclosed):

Name:____

ID# or DOB:____

Substance Abuse Provider: ______________________________ ("Provider")

Background: The behavioral health organizations (BHOs) listed below contract with the State of Colorado to provide mental health and substance use services to Medicaid members. The BHOs in turn contract with Provider to provide mental health and substance use services to Medicaid members. Medicaid has assigned you to one of the BHOs for the management of your services. The BHOs process claims for services submitted by Provider. The BHOs are also required to submit information on all claims paid or processed to Colorado Medicaid for Medicaid administration purposes.

- I hereby authorize Provider to disclose my health information, including information related to my treatment for alcohol and/or drug abuse, to one of the BHOs listed below to which I have been assigned for the purpose of Provider submitting claims for payment to the BHO.
- I hereby further authorize the BHO listed below who has received and processed a claim for services delivered to me by Provider, to re-disclose such information to Colorado Department of Health Care Policy and Financing (Medicaid) for its Medicaid administration purposes as is required by the contract that the BHO has with Medicaid.

BHOs Authorized to Receive and Re-Disclose Information:

Access Behavioral Care
Behavioral Healthcare, Inc.
Colorado Health Partnerships
Foothills Behavioral Health Partners, LLC
Northeast Behavioral Health Partnership

- My treatment may not be conditioned if I do not sign this form.
- I have received a copy of this signed document.
- I understand that I may revoke this authorization at any time by giving written notice to Provider, except to the extent that the Provider or the BHO has already acted on it.
- This authorization will expire on the date that I am no longer a Colorado Medicaid member or two years from the date of my signature, whichever is earlier.

____ ________________

Signature of Member or Legal Representative | Date Signed

____ ______________________

Print Name of Legal Representative (if applicable) | Relationship to Client