Case Management Consent Form and Release of Medical Information

Member Name: ______________________________ __________________ ________________
Last First Middle

Date of Birth:___________________________Contract Number:__________________________________

I agree to participate in the case management program administered by YourCare. Services may include general health education, monitoring, compliance counseling and coordination of care as related to general health and social needs. By agreeing to participate and by signing this form below:

1. I consent to being contacted by telephone, in writing, and in person by the YourCare case manager(s).

2. I understand that: (a) case management services <u>may</u> include an arrangement for coverage of services not otherwise covered under the health insurance contract, if alternative benefits would be more cost-effective than the benefits available under the contract; (b) the decision to offer alternative benefits is made solely by YourCare; (c) approval of an alternative benefit is not a guarantee of any future alternative benefit; (d) alternative benefits are subject to ongoing review and may be discontinued at any time.

3. I understand that:
   - The case management program is voluntary, and I may withdraw from the program at any time upon notification to YourCare.
   - This consent to case management is not a condition for receiving care or treatment by your physician or coverage by your health plan.
   - This consent is to remain in effect as long as you remain in YourCare case management.
   - This consent may be revoked in writing at any time by notifying the case manager.
   - I understand that I am bound by the contractual provisions of the insurance contract and the case management program policies and guidelines of YourCare.

4. I understand that my medical information will be released only as I permit as indicated on the reverse side of this document.

_____ ☐ I Consent to receive text messages or ______ ☐ I Decline to receive text messages

Member Signature:_______________________________________Date:_____________________________

Authorized Representative:________________________________Relationship:______________________

In the event that verbal consent was received through telephone contact, please indicate the date and time of the contact and check the appropriate box below:

☐ I Consent to Case Management or ☐ I Decline Case Management
☐ I Consent to receive text messages or ☐ I Decline to receive text messages

Date: _______________ Time: ___________ Staff Signature: ______________________________________

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Release of Medical Information

Please Complete All 3 Sections & Sign below

Section A

Check all that apply: **ONLY INFORMATION CHECKED BELOW IS APPROVED FOR RELEASE**:

____Assessment/Evaluation
____Diagnosis
____Lab/Test results
____Treatment Plan/Recommendations
____Discharge Summary
____Medical Assessment
____Educational Testing
____Other:____
____All clinical records
____Progress Notes
____Genetic Testing

Purpose or need for disclosure: The information identified above will be disclosed for the purpose of providing and coordinating your care as well as any related health and social services you may require, as part of Monroe Plan's case management program.

Section B Please check at least one box in both categories:

Permission is given to:
☐ YourCare
☐ Healthcare Providers from which I receive healthcare.
☐ Other:____

To disclose information to:
☐ YourCare
☐ Healthcare Providers from which I receive healthcare services and other agencies whose services will support the care and services provided.
☐ Other:____

Section C: Please check all those that apply:

☐ I, the undersigned, have read the above and authorize the practitioner, agency or organization named in Section B to disclose general medical information.
☐ I, the undersigned, have read the above and authorize the practitioner, agency or organization named in Section B to disclose substance abuse (alcohol/drug) treatment information. I understand that any disclosure of the records of Federally assisted alcohol or drug abuse treatment programs is bound by Title 42 of the Code of Federal Regulations.
☐ I, the undersigned, have read the above and authorize the practitioner, agency or organization named in Section B to disclose mental health information.

I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire one year from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply.

Time period, event or condition replacing period specified above:_______________________________

____
Member signature Date

____
Signature of Personal Representative of member, if applicable:
☐ Parent ☐ Legal Guardian ☐ Other:_____________________

____
Print Name of Member

In the event that verbal consent was received through telephone contact, please indicate the date and time of the contact and check the appropriate box: ☐ Consents to release of information indicated above ☐ Declines release of information

Date:______________Time:________________Staff Signature: ____

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I hereby cancel my authorization to release the information outlined on this form.

____
Member signature Date

This consent is voluntary. Neither YourCare nor any other provider or agency participating in the *Case Management Program* may condition treatment or benefits on my willingness to sign this authorization.