

APPENDIX I: HIPAA Authorization Forms

Caregiver HIPAA Authorization for Medicaid Data Linkage.....I-1
Legal Guardian HIPAA Authorization for Medicaid Data Linkage.....I-3

Caregiver HIPAA Authorization for Medicaid Data Linkage

Authorization for Use or Disclosure (Release) Health Information National Survey of Child and Adolescent Well-Being (NSCAW)

Child Name: _____

First Middle Last

Child's Date of Birth: ____/____/____

Month/Day/Year

We would like to better understand the types of health care your child may receive. Linking interview data from you and your child to information on Medicaid services your child receives helps researchers have a complete picture of the services your child receives. Only NSCAW researchers at RTI International will have access to your child's health information.

If you sign this document, you give consent to the U.S. Department of Health of Human Services (DHHS) and Centers for Medicare and Medicaid Services (CMS) to use or release your health information as described here:

I, the signer, allow the release of my child's personal identifiable health information for research as described below:

The health information we may use or release for this research includes:

Medicaid services that _____ may receive including:
(Child Name - First, Middle, Last)

- Type of Inpatient or Outpatient Services
- Diagnoses
- Medications Prescribed
- Payments for Services or Medications

I authorize the release of my child's health information to the following group:

NSCAW researchers at RTI International, Research Triangle Park, NC.

The law requires DHHS and CMS to protect your child's health information. Your signature allows DHHS and CMS to use and/or release your child's health information for this research.

DHHS or CMS cannot withhold or refuse treatment, payment or enrollment in a health plan. Agreeing to this request will not affect your eligibility for benefits.

You may change your mind and cancel this agreement at any time. If you decide to withdraw your approval in the future, CMS and DHHS will not provide new health information to the research project. The health information already provided will continue to be part of the research process.

To withdraw your approval, you must contact:

RTI International
Attention: RTI Privacy Officer
3040 E. Cornwallis Road
P.O. Box 12194
Research Triangle Park, NC 27709-2194
(800) 334-8571 extension 22742

This agreement does not have an expiration date.

Printed Name of Child's Parent/Guardian: _____
First Middle Last

Signature of Child's Parent/Guardian:

Date: ____/____/_____
Month/Day/Year

To withdraw your approval, you must contact:

RTI International
Attention: Privacy Officer
3040 E. Cornwallis Road
P.O. Box 12194
Research Triangle Park, NC 27709-2194
(800) 334-8571 extension 22742

This agreement does not have an expiration date.

Printed Name of Child's Parent/Guardian: _____

First Middle Last

Signature of Child's Parent/Guardian:

Date: ____/____/_____

Month/Day/Year