APPENDIX I: HIPAA Authorization Forms

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.

Your child's information may be provided, as part of this research, to persons who may not be required by Federal privacy laws (such as HIPAA) to protect it and may further share your information with others without your permission, if permitted by laws governing them.

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.

You will be provided a copy of this form.

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 will expire at the end of this research study or when your child turns 18 and reaches the age of legal consent.

Printed Name of Child's Parent/Guardian: _____

First Middle Last

Signature of Child's Parent/Guardian:

_____

Date: _____/___/_____

Month/Day/Year

Legal Guardian HIPAA Authorization for Medicaid Data Linkage

Legal Guardian Authorization for Use or Disclosure of 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 this child may receive. Linking the child's interview data to information on Medicaid services helps researchers have a more complete picture of the services the child receives. Only NSCAW researchers 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 this 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 this 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 health information. Your signature allows DHHS and CMS to use and/or release this child's health information for this research.

DHHS or CMS cannot withhold or refuse treatment, payment or enrollment in a health plan. Your agreement to this request does not affect the child's eligibility for benefits.

The child's information may be provided, as part of this research, to persons who may not be required by Federal privacy laws (such as HIPAA) to protect it and may further share your information with others without your permission, if permitted by laws governing them.

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.

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Printed Name of Child's Parent/Guardian: _____

First Middle Last

Signature of Child's Parent/Guardian:

_____

Date: _____/___/_____

Month/Day/Year