**OFFICE OF THE GOVERNOR**

**AMERICAN SAMOA MEDICAID STATE AGENCY**

**PO BOX 998383**

**AMERICAN SAMOA 96799**

**PH: (684)699-4777 | FAX: (684) 699-4780**

**Medicaid Copay Assistance Patient Consent Form**

***Please read below before signing.***

The Health Insurance Portability and Accountability Act (HIPAA) Public Law 104-191 established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As a patient of the Medicaid Copay Assistance Program, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in the need of your health care information regarding treatment, payment, or health care operations, in order to provide health care that is in your best interest.

You may refuse to consent to the use or disclosure of your personal health information but this must be done, in writing, signed by you. Under this law, the Medicaid Office has the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previous signed agreement.

The Medicaid Office will collect, use and disclose information about you for the following purposes:

* To determine Medicaid eligibility pursuant to Section 2 of the AS Medicaid State Plan.
* To establish and maintain communication with you.
* To contact U.S. Medical Providers to ensure accurate, clean claims were submitted to Medicaid.
* To process and pay clean claim(s) submitted to Medicaid.

By signing this consent section of this Patient Consent Form, you agree that you have given your informed consent to the collection, use and/or disclosure of your personal and medical information for the purposes that are listed. If a new purpose arises for the use and/or disclosure or personal information, we will seek your approval in advance.

**The patient understands that:**

* Protected health information may be disclosed or used for treatment, payment, or health care operations.
* The patient has the right to restrict the uses of their information but Medicaid does not have to agree to those restrictions.
* The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
* Medicaid may condition receipt of treatment upon execution of this consent.

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| **This consent was signed by:** |  | |
|  | **Printed Name-Patient or Legal Guardian** | **Date** |
|  |  | |
|  | **Relationship to Patient (if other than the patient)** | |
|  |  | |
|  | **Signature** | **Date** |
| **Witness:** |  | |
|  | **Printed Name of Medicaid Representative** | |
|  |  | |
|  | **Signature** | **Date** |

**IMPORTANT MESSAGE**: The consent form is only valid for the duration of your medical referral under the American Samoa Medicaid Copay Assistance Program. You may revoke the appointment at any time in writing and may submit it to us either in email at [omr@medicaid.as.gov](mailto:omr@medicaid.as.gov) or at our office located at the ASTCA Executive Building Suite 306 in Tafuna.