HEALTHCHOICES
HealthConnections
*Improving behavioral & physical health care coordination*

# Consent to Release Protected Health Information (PHI)

**Which County does the member reside in?**
Check the box next to the County where the member currently lives.

| ☐ Bucks County: | ☐ Cambria County: | ☐ Lehigh County: | ☐ Montgomery County: | ☐ Northampton County: |
|---|---|---|---|---|
| 877-769-9784 | 800-424-0485 | 866-238-2311 | 877-769-9782 | 866-238-2312 |

HealthChoices HealthConnections is a partnership between Magellan Behavioral Health of Pennsylvania, the above mentioned County Behavioral Health Offices, and the Pennsylvania Department of Human Services. We can help you better if we are able to work together and with providers that know about you.

By signing this form, you are telling us that it is **OK** for the partners listed above and providers listed in Part 2 to share health information about you with each other. If you do not want to share this information, you cannot be in this program. But even if you do not sign this form, your HealthChoices benefits will stay the same with Magellan, the County Behavioral Health Offices, and the Department of Human Services. These partners may still share information about you even if you do not sign this form, but only in the way it says in the law. If you have questions, please ask the person who gave you this form to tell you about your rights or more details about how your health information is shared. If you still have questions, we can help. Call Magellan at the toll-free numbers listed above. Members who are hearing impaired can reach us by using PA Relay 7-1-1.

## Part 1 Who is the member?

I say it is **OK** to let the HealthChoices HealthConnections partners listed above use/disclose the health information listed below in Part 3.

| Last Name | First Name | | Middle Initial |
|---|---|---|---|
| Medical Assistance ID Number (MAID #, required) | Date of Birth (MM/DD/YYYY) | Phone Number (with area code) | |
| Address | City | State | Zip Code |

## Part 2 Who can the PHI be given to?

Besides the HealthChoices HealthConnections partners, this information can also be shared with:

**Physical Health HealthChoices Managed Care Organization (PHMCO)**:
Insert name, address, and phone number of the PHMCO that your health information can be shared with

**Primary Care Doctor (PCP)**:
Insert last name, first name, address, and phone number of the PCP that your health information can be shared with (Please do not include the name of the practice)

**Medical Health Specialist**:
Insert last name, first name, address, and phone number of your specialist that your health information can be shared with (Please do not include the name of the practice)

**Mental Health Provider**:
Insert name, address, and phone number of the provider group that your health information can be shared with

**Mental Health Provider**:
Insert name, address, and phone number of the provider group that your health information can be shared with

**Other Health Care Provider**:
Insert last name, first name, address, and phone number of the provider that your health information can be shared with (Please do not include the name of the practice if this is a physical health provider)

**Other Health Care Provider**:
Insert last name, first name, address, and phone number of the provider that your health information can be shared with (Please do not include the name of the practice if this is a physical health provider)

**Other Health Care Provider**:
Insert last name, first name, address, and phone number of the provider that your health information can be shared with (Please do not include the name of the practice if this is a physical health provider)

**Other Health Care Provider**:
Insert last name, first name, address, and phone number of the provider that your health information can be shared with (Please do not include the name of the practice if this is a physical health provider)

## Part 3 What PHI can we share?

My general physical and mental health information will be shared if I sign this form. And **IF** my records have drug and/or alcohol or HIV related information, I want to share that information as shown below:

**Drug and Alcohol Information - <u>IF</u>** my records have drug and alcohol information, I **<u>want</u>** to share it with the partners and the providers in Part 2 of this form.

☐ Yes, share all drug/alcohol information.

☐ No. If you say no, you **<u>cannot</u>** be in the HealthChoices HealthConnections program.

**HIV/AIDS Information - <u>IF</u>** my records have HIV/AIDS information, I **<u>want</u>** to share it with the partners and the providers in Part 2 of this form.

☐ Yes, share all HIV/AIDS information.

☐ No. If you say no, you **<u>cannot</u>** be in the HealthChoices HealthConnections program.

## Part 4 Why are you giving out this PHI?

Sharing this information lets my physical health care and behavioral health care providers and all the HealthChoices HealthConnections partners work together to help me better.

## Part 5 I understand that:

I can take back my OK on this paper at any time. This will not take back the information that was already shared but it will make sure no more information is shared.

If I want to take back my OK, I must let Magellan know in writing. It can be mailed to:

Magellan Behavioral Health of PA
HealthChoices HealthConnections Consent Office
105 Terry Drive, Suite 103
Newtown, PA 18940

I will still get benefits and treatment even if I do not sign this form.

Information that is shared from this form may be shared again by those who receive it. If this happens, it may not be protected by federal or state privacy laws. These laws do not always apply to everyone. **But my drug and alcohol information and my HIV status cannot be shared again further unless I give another OK in writing.**

## Part 6 Signature of Member

My OK lasts for **two years** from when I sign this form. It also ends if I take back my OK, whichever happens first.

I give my **OK** to share the information listed in this paper.

Signature or Mark of Member _____ Date _____

## Part 7 Signature of Authorized Representative (If Any)

**Authorized Representative** means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own.

Signature of Person Signing on Behalf of Member _____ Date _____

Print Name: _____ Phone Number: _____

Address: _____

## Part 8 Signature of Witness (Required)

Witness Signature: _____ Date: _____

Print Name: _____

## Notice to Anyone Other Than the Patient

**Disclaimer:** This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.