Magellan Behavioral Health of Pennsylvania, Inc.
Consent to Release Protected Health Information (PHI)

Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) managing care for:
Pennsylvania Health Choices – Bucks, Cambria, Lehigh, Montgomery, and Northampton Counties

Protected Health Information (PHI) means information about your health. Federal and state laws protect the privacy of your PHI. The laws say we cannot give anyone other than your doctors or Pennsylvania Health Choices your PHI unless you say it is **OK.** By signing this paper, you give us your **OK.** We will only give out the PHI that you say we can share. And, we will only give it to the people or agencies that you list. Do you have questions? We can help. Call Magellan at:

Bucks County:	Cambria County:	Lehigh County:	Montgomery County:	Northampton County:
1-877-769-9784	1-800-424-0485	1-866-238-2311	1-877-769-9782	1-866-238-2312

Members who are hearing impaired can reach us by using PA Relay 7-1-1

YOU MUST FILL OUT ALL PARTS OF THIS FORM. IF ANY PART IS LEFT BLANK IT WILL BE RETURNED TO YOU TO FIX.

Part 1 Who is the member?

Last Name	First Name	Middle Initial

ID Number	Date of Birth (MM/DD/YYYY)	Phone Number (with area code)

Address	City	State	Zip Code

Check One:

☐ I am the member **OR** ☐ I have the legal right to act for this person. (Check one below; if "other" fill in blank):
I'm his or her: ☐ Parent **OR**
☐ Guardian/Other (Legal Documentation Required) _____

Part 2 Who can give out the PHI?

Magellan may give out your PHI. Magellan manages your mental health and/or drug and alcohol treatment for Pennsylvania Health Choices in your County.

Part 3 Who can PHI be given to?

Please write **the person's first and last name** OR **the name of the place/facility/doctor** that can have your PHI. We also need the phone number and address if you know it. Only list one (1) person or place in this part.

Name/Facility/Doctor (please be as specific as possible)	Phone Number (with area code)

Address	City, State, and Zip Code

Part 4 What PHI can we share?

We will **only** share the PHI that you **OK**. Write down exactly what kind of PHI we can share on the lines below. Give the date or place if you can (for example, "information about all my care in June 2011"). It may include facts about your medicine, your mental health and/or your alcohol and drug treatment. It does not cover psychotherapy notes that are not in your medical records. _____

If it is okay to include this kind of health information in the PHI you told us to share above, tell us by checking the box. **(Check all that apply):**

☐ HIV/AIDS ☐ Alcohol/Substance Abuse Records ☐ Sexual/Physical/Mental Abuse

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Part 5 Why are you giving out this PHI?

Tell us **why** you want us to share your PHI (this section must be completed and can't be left blank): _____

Part 6 When does my OK end?

Please tell us the date or event you want us to stop sharing your health information. Your OK will end when you tell us it does. **Tell us when you want your OK to end:**

☐ **My OK ends on this date** _____ (Please enter a date on this blank line. If you do not tell us when your OK ends then we will end your OK in one year from when you sign.)

OR

☐ **My OK ends when this happens:** _____
(It can be something like – *you can share my information this one time*. Or "when I come out from the hospital in one month". It cannot be "forever" or "when I die". The event must be within one year from when you sign)

Part 7 Your Rights and Important Facts

- Giving your OK is up to you. You do not have to share your information.
- You do not have to OK this paper. You will still get benefits and treatment.
- You can take back your OK. You must tell us in writing. Mail it to: Magellan Behavioral Health of Pennsylvania, Inc., 105 Terry Drive, Suite 103, Newtown, PA 18940
- What if you take back your OK? This will not take back the PHI that we have already shared. But, we will not share any more of your PHI.
- If we share your PHI with the people or agencies that you named, they may share it with others. Not everyone has to follow privacy rules.
- You have a right to get a copy of this signed OK. If you need another copy, call Magellan at the number listed above.
- If you do not understand, or have questions, we can help. Call Magellan at the number listed above.
- You should get a copy of this signed paper. Remember, Protected Health Information (PHI) means any information about your health in the past, present, or future. It includes facts like your address and date of birth. A full definition of PHI is at 45 CFR §160.103.

Part 8 Signature of Member

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

_____ _____

Signature or Mark of Member **Date (required)**

Part 9 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. If the member is less than 18 years old, a parent or guardian should sign for the minor. If you have legal proof that you can act for this person, please submit that documentation along with this form.

_____ _____

Signature of Person signing on behalf of member **Date (required)**

Printed Name: _____ **Phone:** _____

Address: _____

NOTICE TO ANYONE OTHER THAN THE MEMBER

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.