## INSTRUCTIONS

**PLEASE MAKE SURE ALL SECTIONS OF THE FORM ARE FILLED IN**
**OR THE FORM WILL BE SENT BACK TO YOU AS WE WILL NOT BE ABLE TO COMPLETE THE REQUEST**

### Section 1. MEMBER INFORMATION

This is information about the person whose Protected Health Information (PHI) will be shared. Please print the:

- member's first and last name;
- address; and,
- date of birth

Please also include the Medicaid Assistance ID number of the member who is giving Magellan the OK to share their PHI.

In the area below the Member Information section "*Please Check One of the Following*," please mark one (1) box to tell us who is filling out this form.

- If it is you, the member, then mark the first box **OR**
- If it is someone who the law says can act for the member, please mark the second box.

If you check the second box, then you also need to tell us who you are.

- If you are the Parent, mark the first box.
- If you are the member's legal guardian or someone else, mark the second box. Please write your relationship to the member on the blank line.

### Section 2. WHO YOUR PHI MAY BE GIVEN TO

This section identifies the person and/or the organization that we will share the PHI of the person listed in section 1 with. Please add the name and/or organization that you wish to receive your PHI.

- This information will assist in limiting the release of PHI to only the person and/or the organization you OK.

This section allows, if you check the box, to make this an OK for all future uses and disclosures for treatment, payment, and health care operations for substance use disorder information only.

- If you choose to mark this box, please describe the person who will get the PHI like "my treating providers, health plans, third-party payers, and people helping to manage my care or benefits" or something like that.

### Section 3. REASON YOU WANT US TO SHARE YOUR PHI

This section tells us why you want to release your PHI. Please provide the reason the PHI is being shared. If you do not wish to provide a specific reason, and you OK this PHI to be shared, you may write "at the request of the individual" in this section. If no reason for sharing the PHI is listed, the form will be returned to you as incomplete.

### Section 4. SHARE THIS PHI ABOUT ME (check one or more)

This section tells us the type of PHI we can release. We will only share the PHI that you OK. Please check the box(es) to let us know the exact mental health and/or substance use disorder information we can share:

- Select from the four (4) options listed.

- If you select "*Other,*" please write in the specific PHI you wish to share. If no explanation is listed, we will not know what to share and the form will be returned to you as incomplete.

**Section 5. <u>WHEN WILL YOUR OK END?</u>**

This section tells us when your OK expires. **Please choose only one (1) choice to let us know when you want your OK to end**.

- If choosing *My OK ends on this date* - it must be a valid date (month, date, and year) and must not be more than one (1) year from the date the form was completed.
- If choosing *My OK ends when this happens* - it should relate to the purpose of the disclosure, and it must occur within one (1) year from the date the authorization form is signed.

By choosing an expiration date OR event, this limits the span of time during which your PHI can be shared.

If none of the three (3) options is selected, your OK will expire one (1) year from the date signed in Sections 7 or 8, as applicable.

**Section 6. <u>YOUR RIGHTS & IMPORTANT FACTS</u>**

This section lists your rights. Please read all of this section as it explains your rights and other important things.

**Section 7. <u>MEMBER SIGNATURE</u>**

This is where you sign your name and provide the date you signed the form.

- Your PHI cannot be shared if you do not **sign AND date** the form.
- Please note, there are some states where children who are old enough are the ones who need to sign so that we can share their mental health and substance use disorder PHI.
    - In Pennsylvania, minors 14 years and older can consent to inpatient and outpatient mental health services and control disclosure of such records. For substance use disorder treatment please note the following:
        - Inpatient treatment: minors under 18 years old may not consent
        - Outpatient treatment: any age may consent

**Section 8. <u>AUTHORIZED PERSONAL REPRESENTATIVE SIGNATURE</u>**

This section tells us the person who can act on the member's behalf. If applicable, please have the personal representative sign in this section.

- An authorized personal representative has the legal authority to act on the member's behalf.
- **Please provide documentation to prove the legal authority.**
    - Example: ■ Health Care Power of Attorney ■ Guardianship

**Section 9. <u>WHERE TO SEND THIS FORM & ASK QUESTIONS</u>**

This section provides contact information for where to submit the form or in case you have questions.