Magellan HEALTHCARE℠

Magellan Behavioral Health of Pennsylvania, Inc.
Consent to Release Protected Health Information (PHI)
For Purposes Of: HealthChoices Integrated Health Program

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

- ☐ Bucks County: 1-877-769-9784
- ☐ Cambria County: 1-800-424-0485
- ☐ Lehigh County: 1-866-238-2311
- ☐ Montgomery County: 1-877-769-9782
- ☐ Northampton County: 1-866-238-2312
- ☐ Somerset-Bedford Counties: 1-800-424-5860

Is the member currently enrolled in a Wellness Recovery Team or Nurse Navigator Program? ☐ Yes ☐ No

Magellan Behavioral Health of Pennsylvania (Magellan) partners with the above mentioned County Behavioral Health Offices and the Pennsylvania Department of Human Services to help with your care. We can help you better if we are able to work together with others that know about you.

By signing this form, you are telling us that it is **OK** for the partners listed above and agencies/individuals listed in Section 2 to share Protected Health Information (PHI) about you with each other. PHI means information about your health. There are laws that protect the privacy of your PHI. These laws say we cannot give your PHI to anyone else except your current doctor and Pennsylvania HealthChoices (Magellan manages your mental health and substance use disorder care for them) unless you say it is OK. If you do not sign this form, your Behavioral Health HealthChoices Medicaid benefits will stay the same. These partners may still share information about you even if you do not sign this form, but only in the way allowed by 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.

You must complete ALL sections of this form.

If any sections are left blank, this form will not be acceptable, and your PHI will not be shared.

Section 1 MEMBER INFORMATION (REQUIRED)

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

Last Name	First Name		Middle Initial
Medical Assistance ID Number (Access Card)	Date of Birth (MM/DD/YYYY)	Phone Number (with area code)	
Address	City	State	Zip Code

Section 2 WHO YOUR PHI MAY BE GIVEN TO (REQUIRED)

The information listed below in Section 4 will be shared with the above HealthChoices partners, as well as with the agencies/individuals listed below. I consent to my information being shared with the below agencies/individuals for the HealthChoices Integrated Health Program.

☐ Note for substance use disorder information only: Please check here if you want to make this an OK you give one time for all future uses and disclosures for treatment, payment, and health care operations with your treating providers, health plans, third party payors, and people helping to manage your care or benefits. If you OK this, we will share substance use disorder PHI with the agencies/individuals listed below.

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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)

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Section 3 REASON YOU WANT US TO SHARE YOUR PHI

Sharing this information will help these agencies/individuals and HealthChoices partners in making decisions regarding me and my outcomes.

☐ Note for substance use disorder information only: Please check here if you are giving us an OK one time for all future uses and disclosures for treatment, payment, and health care operations.

Section 4 SHARE THIS PHI ABOUT ME

My physical, behavioral health, and substance use disorder information will be shared if I sign this form. This may include current and/or past treatment history. **IF** my records have HIV/AIDS related information, I **want** to share it with the partners and the providers listed in Section 2 of this form as shown below:

☐ Yes, share all of my HIV/AIDS information.

☐ No. When applicable, if you say no you **cannot** be in the HealthChoices HealthConnections program.

Section 5 WHEN WILL YOUR OK END?

My OK will end two years from the date I sign this form or when I leave the HealthChoices Integrated Health Program, whichever happens first. It also ends if I take back my OK, whichever happens first. (See Section 6 to find out how to take back your OK)

Section 6 YOUR RIGHTS & IMPORTANT FACTS

- Giving your OK is up to you. You do not have to share your information.
- You do not have to OK this form. You will still get benefits and treatment.
- You can take back your OK. You must tell us in writing. Mail it to the address listed in Section 9 below. 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 organization that you named, they may share it with others. Not everyone has to follow privacy rules.
- You should keep a copy of this signed OK. If you need another copy, please call Magellan at the phone number listed at the top of this form and we will send you a copy.
- If you do not understand anything on this form or if you have questions, we can help. Please call the phone number listed at the top of this form.
- For substance use disorder information: If the person or group listed in Section 2 above is a covered entity or business associate and gets your information for treatment, payment, or health care operations reasons, your information may be shared again by them as long as they follow the permissions in the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you.

A SIGNATURE AND DATE ARE REQUIRED IN EITHER SECTION 7 OR 8 BELOW

Section 7 MEMBER SIGNATURE

I give my OK to share the information listed in Section 4 with the agencies/individuals listed on this form for the HealthChoices Integrated Health Program. If you do not sign, we cannot accept this form.

Signature or Mark (Required)	
Date (Required)	

(See *NOTICE TO RECIPIENT OF INFORMATION* on next page; it must be included when submitting this form.)

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Section 8	**AUTHORIZED PERSONAL REPRESENTATIVE SIGNATURE (If Any)**
Authorized Personal Representative means you have legal proof that you can act for this person. If applicable and the Authorized Personal Representative does not sign, we cannot accept this form.	
Signature (Required, If Applicable)	
Print Name (Required, If Applicable)	
Date (Required, If Applicable)	
Please tell us your legal proof to act for this person. We may ask you to send us proof. (*REQUIRED*)	

Section 9	**SIGNATURE OF WITNESS (Required)**
Signature (Required, If Applicable)	
Print Name (Required, If Applicable)	
Date (Required, If Applicable)	

Section 10 WHERE TO SEND THIS FORM & ASK QUESTIONS

After you fill in and sign this form, send it to us via one of the ways listed below. If you have any questions about how to complete this form, you can use any of these ways to contact us. Remember, PHI means information about your health in the past, present, or future. It includes facts like your address and date of birth, too. A full definition of PHI is at 45 CFR 160.103.

Mailing Address:	**Fax:** (Preferred)
Magellan Behavioral Health of PA 790 Township Line Road, Suite 120 Yardley, PA 19067	1-866-667-7744

NOTICE TO RECIPIENT OF INFORMATION

This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies:

(i) Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2.

(ii) You are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or

(iii) You have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A & E.

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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.

Section 2. WHO YOUR PHI MAY BE GIVEN TO

This section identifies the providers that will receive the PHI of the person listed in section 1 for purposes of the HealthChoices Integrated Health Program.

This section must be completed or we cannot accept the form.

This information will assist in limiting the release of PHI to only the providers you OK.

Section 3. REASON YOU WANT US TO SHARE YOUR PHI

This section tells us why you want to release your PHI. Sharing your PHI will help the HealthChoices partners and your providers in making decisions regarding you.

Section 4. SHARE THIS PHI ABOUT ME

This section tells us the type of PHI we can release. If you sign this form, your physical, behavioral health, and substance use disorder information will be shared with the HealthChoices partners, and the providers that you OKed in Section 2 for the HealthChoices Integrated Health Program.

Section 5. WHEN WILL YOUR OK END?

This section tells us when your OK expires. Your OK will end two years from the date this form is signed or when you leave the HealthChoices Integrated Health Program, whichever happens first.

Section 6. YOUR RIGHTS & IMPORTANT FACTS

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

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Section 7. MEMBER SIGNATURE

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.

Section 8. AUTHORIZED PERSONAL REPRESENTATIVE SIGNATURE

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.**
  - Examples: ■ Health Care Power of Attorney ■ Guardianship

Section 9. SIGNATURE OF WITNESS

This section tells us who witnessed the member/authorized personal representative sign the form.

Section 10. WHERE TO SEND THIS FORM & ASK QUESTIONS

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

NOTE: The *NOTICE TO RECIPIENT OF INFORMATION* found on page 4 MUST be included when you submit this form or Magellan cannot accept it.

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