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

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

This form should be used to give your OK to Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) so that we can share your *Protected Health Information (PHI)* with some other person or organization. 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. ***By filling out and signing this form, you say that it is OK for Magellan to give out the PHI that you tell us we can share***. 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 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.

| 1 | MEMBER INFORMATION | | | |
|---|---|---|---|---|
| REQUIRED | **Last Name** | **First Name** | **Middle Initial** | **Date of Birth** |
| | **Medical Assistance ID Number (ACCESS Card)** | | **Phone Number** | |
| | **Street Address** | **City** | **State** | **Zip Code** |
| | **Please check ONE of the following:**<br>☐ I am the member (sign below in Section 7)<br>☐ I have the legal right to act for this person because I am their: (please check one) (sign below in Section 8)<br>☐ Parent OR<br>☐ Guardian/Other (Legal Documentation Required)<br>Explain Relationship: | | | |

| 2 | WHO YOUR PHI MAY BE GIVEN TO | | | |
|---|---|---|---|---|
| REQUIRED | Fill in the name of the person **AND/OR** the organization that we can share your PHI with. | | | |
| | **Name** (this can be a person or a specific group of persons like "detox hospitals in PA") | | | |
| | **Organization** (Provider Name; Children & Youth, etc.) | | **Phone Number** | |
| | **Street Address** | **City** | **State** | **Zip Code** |
| | **Note for substance use disorder information:** 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, you can say "my treating providers, health plans, third-party payers, and people helping to manage my care or benefits" or something close to that.<br>☐ Please check here if you wish 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 OK this, we will share the substance use disorder PHI with the person or organization listed above. | | | |

| 3 | REASON YOU WANT US TO SHARE YOUR PHI |
|---|---|
| REQUIRED | Tell us why you want us to share your PHI. We need to know the reason. Examples might be "to help find a facility or provider for a referral for services", "to allow someone (family member, friend, etc.) to help me with my care", "Coordination of Care", "for help with my Complaint or Grievance", etc. |
| | **Note for substance use disorder information**: saying "For treatment, payment, and health care operations" is fine when you are giving us an OK one time for all such future uses or disclosures of that kind. |
| | |

| 4 | SHARE THIS PHI ABOUT ME (check one or more) | | |
|---|---|---|---|
| REQUIRED | We will only share the PHI that you OK. This OK includes facts that we have about care you receive(d) for your mental health and/or substance use disorder, including medicines. It does not cover psychotherapy notes that are not in your medical records. Please check the box(es) to let us know the exact mental health and/or substance use disorder information from your records that we can share. | | |
| | ☐ | Claims Information | Includes information related to Magellan's payment of claims for services received, including information located on a claim form (i.e., billed amount, general procedure descriptions, denial reasons, etc.) |
| | ☐ | Benefit Determination Information | Includes information related to pre-service, concurrent, and post-service benefit decisions made by Magellan |
| | ☐ | Entire Member Record | This will be all of the facts Magellan has about you in our system |
| | ☐ | Other (be specific) | Examples might be: details about your appeal, or facts about your past services history, or PHI about your current care |

| 5 | WHEN WILL YOUR OK END? | |
|---|---|---|
| REQUIRED | Your OK will end when you tell us it does. We need you to tell us a date or event when your OK ends. Please check one of the following: | |
| | ☐ | My OK ends one year from the date when I sign below. |
| | ☐ | My OK ends on this date: _____<br>Note: It cannot be more than one year from the date you sign below. |
| | ☐ | My OK ends when this happens:<br><br>(It can be something like "when my appeal is done" but it must happen within 1 year) |
| | If an option is not selected or the end of your OK that is listed in this Section is longer than one year, your OK will end one year from the date this form is signed. | |

## 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

| 7 | MEMBER SIGNATURE | |
|---|---|---|
| REQUIRED | I give my OK to share the information listed to the person or organization in this form. If you do not sign, we cannot accept this form. In some states, 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. (See below AUD instructions for examples) | |
| | Signature or Mark (Required) | |
| | Date (Required) | |

| 8 | AUTHORIZED PERSONAL REPRESENTATIVE SIGNATURE | |
|---|---|---|
| REQUIRED (If Applicable) | 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) | |
| | Printed Name (Required) | |
| | Date (Required) | |
| | Please tell us your legal proof to act for this person. We may ask you to send us proof. (*REQUIRED*) | |
| | | |

| 9 | WHERE TO SEND THIS FORM & ASK QUESTIONS | |
|---|---|---|
| After you fill in and sign this form, send it to us 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:** (Preferred)<br><br>Magellan Behavioral Health of PA<br>790 Township Line Road, Suite 120<br>Yardley, PA 19067 | **Fax:** (Preferred)<br><br>1-866-667-7744 | **Email Address:** (Not preferred; email may not be a secure method)<br><br>PAHC_Aud@magellanhealth.com |

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.

## 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.