## 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**

**Protected Health Information (PHI)** means information about your health. Federal and state laws protect the privacy of your PHI. These laws say we cannot give anyone other than your doctors or Pennsylvania HealthChoices 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.

| | | | | |
|---|---|---|---|---|
| **1** **Member** | **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:**

☐ I am the member – OR –

☐ I have the legal right to act for this person. (Check one below; if "Guardian/Other" fill in the blank)

I am their: ☐ Parent OR

☐ Guardian/Other (Legal Documentation Required): _____

| | |
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| **2** **Who can release the PHI?** | Magellan may give out your PHI. Magellan manages your mental health and/or drug and alcohol treatment for Pennsylvania HealthChoices in your County. |
| **3** **Who can the PHI be given to?** (Fill in Name and/or Organization) | **Name** (individual, or class of persons like "family members residing with me", or "All Family Based Providers", etc.) |
| | **Organization** (Provider Name; Children & Youth, etc.) **Phone Number** |
| | **Street Address** **City** **State** **Zip Code** |

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| **4**<br>**What PHI can we share?** | **We will only share the PHI that you OK with the person/organization you listed in Part 3.** This OK includes facts about your medicine. It also includes facts about your mental health and/or your alcohol and drug treatment that are in your records. It does not cover psychotherapy notes that are not in your medical records. Please be specific and tell us the health information that we can share, including dates and location of services. **For example**, you can say "share all of my information/records"; "share information needed to make a referral for services", or "share information needed for a complaint or grievance that was filed", etc.:<br>_____<br>_____ |
| **5**<br>**What is the Purpose for the Release?** | **Tell us why you want us to share your PHI** - For example, you can say "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", etc.:<br>_____<br>_____ |
| **6**<br>**When does my OK end?** | Your OK will end when you tell us it does. It cannot be more than one year from when you sign.<br>**Tell us when you want your OK to end:**<br>***Please check one:**<br>☐ **My OK ends on (enter date):** _____<br>**– OR –**<br>☐ **My OK ends when this happens:** _____<br>(It can be something like "You can share my counseling records this one time" or "when I come out of the hospital in one month".)<br>**If you do not tell us when your OK ends, then we will end your OK one year from when you sign this form. After one year, will need a new OK from you.** |
| **7**<br>**Your Rights & Important Facts** | • Giving your OK is up to you. You do not have to share your information.<br>• You do not have to OK this paper. You will still get benefits and treatment.<br>• 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<br>• 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.<br>• If we share your PHI with the people or organization(s) that you named, they may share it with others. Not everyone has to follow privacy rules.<br>• You have a right to get 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.<br>• If you do not understand something on this form or have questions, we can help. Please call the phone number listed at the top of this form.<br>• 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. |

*(Go to next page to sign – Required)*

**A SIGNATURE AND DATE ARE REQUIRED IN EITHER SECTION 8 OR 9 BELOW**

**8**

**Member Signature**

(If 14 or older)

I give my OK to share the information listed in this paper. If the member is signing with their mark, their mark MUST be witnessed by someone other than the person listed in Part 3.

| **Signature or Mark (Required):** | **Date (Required):** |
|---|---|
| | |
| Signature of witness if member signed with a mark: | Date (Required): |
| | |

**9**

**Parent or Authorized Representative Signature**

**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/her/their own. If the member is 14 to 17 years old, both the member and a parent/legal guardian should sign this form.

**Use your full legal name. If you have legal proof that you have the right to act on the behalf of the member, please submit it along with this form.**

**Signature of Person signing on behalf of Member (Required):** **Date (Required):**

**Printed Name:** **Phone Number:**

**10**

**Where to Send this Form & Ask Questions**

After you fill in and sign this form, you can mail, fax, or email it to Magellan (see below). If you have any questions about how to complete this form, you can reach us by calling the phone number listed at the top of this form for the County you live in.

| **Mailing Address:** | **Fax:** | **Email Address:** |
|---|---|---|
| Magellan Behavioral Health of PA<br>105 Terry Drive, Suite 103<br>Newtown, PA 18940 | 1-866-667-7744 | 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). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.**