HEALTHCHOICES
HealthConnections
Improving behavioral & physical health care coordination

Consent to Release Protected Health Information (PHI)

HealthChoices HealthConnections is a partnership between Magellan Behavioral Health of Pennsylvania, Keystone Mercy Health Plan, _____, and the Pennsylvania Department of Public Welfare. We can help you better if we are able to work together and with providers that know about you.

By signing this form, you are telling us that it is OK for the partners listed above and providers listed in Part 2 to share health information about you with each other. If you do not want to share this information, you cannot be in this program. But even if you do not sign this form, your HealthChoices benefits will stay the same with Magellan, Keystone Mercy Health Plan, _____, and the Department of Public Welfare. These partners may still share information about you even if you do not sign this form, but only in the way it says in 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.

Part 1 Who is the member?

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

Last Name	First Name	Middle Initial

Medical Assistance ID number (MAID #, required)	Date of Birth (MM/DD/YYYY)	Phone Number (with area code)

Address	City	State	Zip Code

Part 2 Who can the PHI be given to?

Besides the HealthChoices HealthConnections partners, this information can also be shared with:

Primary Care Doctor (PCP): _____

_____
Insert name, address, and phone number of the PCP practice that your health information can be shared with

Medical Health Specialist: _____

_____
Insert name, address, and phone number of the specialty practice 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

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 name, address, and phone number of the provider group that your health information can be shared with

Turn this page over.

Part 3 What PHI can we share?

My general physical and mental health information will be shared if I sign this form. And IF my records have drug and/or alcohol or HIV-related information, I want to share that information as shown below:

Drug and Alcohol Information - IF my records have drug and alcohol information, I want to share it with the partners and the providers in Part 2 of this form.

☐ Yes, all drug/alcohol information. ☐ No. If you say no, you cannot be in the HealthChoices HealthConnections program.

HIV/AIDS Information - IF my records have HIV/AIDS information, I want to share it with the partners and the providers in Part 2 of this form.

☐ Yes. ☐ No. If you say no, you cannot be in the HealthChoices HealthConnections program.

Part 4 Why are you giving out this PHI?

Sharing this information lets my physical health care and behavioral health care providers and all the HealthChoices HealthConnections partners work together to help me better.

Part 5 I understand that:

I can take back my OK on this paper at any time. This will not take back the information that was already shared, but it will make sure no more information is shared.

- If I want to take back my OK, I must tell Magellan. I can do it in one of these ways:
  - Call them at 877-769-9780, OR
  - Mail to:

    Magellan Behavioral Health of PA
    HealthChoices HealthConnections Consent Office
    105 Terry Drive
    Suite 103
    Newtown, PA 18940
- I will still get benefits and treatment even if I do not sign this form.
- Information that is shared from this form may be shared again by those who receive it. If this happens, it may not be protected by federal or state privacy laws. These laws do not always apply to everyone. But my drug and alcohol information and my HIV status cannot be shared again further unless I give another OK in writing.

Part 6 Signature of Member

My OK lasts for two years from when I sign this form. It also ends if I take back my OK, whichever happens first.

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

_____ _____

Signature or Mark of Member Date

Part 7 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.

_____ _____

Signature of Person signing on behalf of member Date

Printed Name: _____ Phone: _____

Address: _____

Part 8 Signature of Witness (Required)

Witness: _____ _____

Signature Date

Printed Name: _____