

## Consent to Release Health Information

Sometimes you need to see a number of different providers to get all the services you require. This includes behavioral health providers and physical health providers. All of your providers and managed care organizations should work together to provide you with the best possible care, but your providers and managed care organizations can only talk to each other with your permission. Please consider giving this permission. By letting your providers and managed care organizations talk to each other, you can verify that your medications are safe to take together, avoid repeat tests, and get help in your recovery.

By signing this form, you are telling us that it is OK for your primary care provider, your behavioral health care providers, your physical health managed care organization and your behavioral health managed care organization to share health information about you for the purpose of planning and coordinating your health care. This helps your providers and managed care companies work together to take better care of you.

If you do not sign this form, your benefits will stay the same. Some information may still be shared even if you do not sign this form, but only in the way it says in the law. If you have questions, about your rights or if you need more details about how your health information is shared, please call the member services number on the back of your behavioral or physical health managed care ID card or in your member handbook.

Part 1 Member Information			
Last Name	First Name	Middle Initial	
Medical Assistance ID number (MAID#)	Date of Birth (MM/DD/YYYY)	Phone Number (with area code):	
Address	City	State	Zip Code

### Part 2 Who can my health information be given to?

This Consent to Release Information is being requested by:

Organization Name: Community Care Behavioral Health Organization	Phone #: 1-888-251-2224 (Provider Service Line) Clinical Fax # 1-888-251-0087
Address One Chatham Center, Suite 700 Pittsburgh, PA 15219	

I agree that my information can be shared with my primary care physician (PCP) below:

Primary Care Provider (PCP) Name:	Phone #:
Address	

I agree that my information can be shared with my behavioral health provider below:

Behavioral Health Care Provider Name:	Phone #:
Address	

I agree that my information can be shared with a second behavioral health provider, including crisis service providers, below (if you have more than one behavioral health provider):

Behavioral Health Care Provider Name:	Phone #:
Address	

I agree that my information can be shared with my physical health or behavioral health managed care organization below. Please check your managed care organization(s):

Behavioral Health Managed Care Organizations

- Community Behavioral Health, Inc
- Community Care Behavioral Health Organization
- Community Behavioral HealthCare Network of Pennsylvania (CBHNP)
- Magellan Behavioral Health
- Value Behavioral Health

Physical Health Managed Care Organizations

- Aetna
- AmeriHealth Mercy
- Coventry Health Care
- DPW Intense Medical Case Management Unit
- Gateway Health Plan
- HealthPartners
- Keystone Mercy Health Plan
- United Healthcare Community Plan
- UPMC Health Plan
  
- APS Healthcare (Access Plus)

**Part 3 Why are you sharing this health information?**

Sharing this information lets my physical health and behavioral health care providers and my managed care plans work together to help me better.

**Part 4 What health information 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 agree to share that information as shown below:

- Yes. **IF** my records have drug and alcohol information, I agree to share all drug/alcohol information with the providers in Part 2.
- No. If you say no, this information will not be shared with any of the providers in Part 2.
  
- Yes. **IF** my records have HIV/AIDS information, I agree to share it with the providers in Part 2.
- No. If you say no, this information will not be shared with any of the providers in Part 2.

**Part 5 I understand that:**

I can take back or cancel my OK on this form 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 the organization who requested this form from Part 2 above. I can call the member services number on the back of my behavioral or physical health managed care ID card or in my member handbook. If this form was requested by someone other than my behavioral health or physical health managed care organization checked in Part 2 above, I should notify that person as well.

**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

- 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. It may not be protected by federal or state privacy laws. These laws do not always apply to everyone. My drug and alcohol information and my HIV status cannot be shared again further unless I give another OK in writing.

**Part 7 Oral Consent**

If oral consent is obtained instead of member's signature:

Oral Consent obtained

\_\_\_\_\_  
Signature of person signing on behalf of member

\_\_\_\_\_  
Relationship to member

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**Part 8 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

\_\_\_\_\_  
Relationship to member

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Witness: \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Printed Name: \_\_\_\_\_

\*\*\*\*Please fax this Consent to the attention of the PH BH AA at 1-888-251-0087.