Instructions

Consent to Release Protected Health Information Form

Consent to Release Protected Health Information (PHI) Form – Use this form to allow us to share your health information.

Please complete the Consent to Release Protected Health Information Form to give us your OK to share your health information.

If you have any questions about anything on this form, call the number listed in Section 7 - Your Rights and Important Facts.

Part 1. Who is the patient?

This is information about you. Please write your name, address, date of birth and Medicaid ID number of the patient who is giving Magellan the OK to share his or her health information.

In the area called "Check One," please check the box to tell us who is filling out the form.

- If it is you, the patient, then check the first box.
- If it is someone the law says can act for you, then check the second box. Next, tell us the first and last name of that person.

Part 2. Who can give out the PHI?

This is information about Magellan Behavioral Health of Pennsylvania, Inc. This section says we can share your health information once you say it is OK.

Part 3. Who can the PHI be given to?

List who we can share your health information with. Please write the person's first and last name or the name of the place that can have your PHI. We also need the phone number and address if you know it. Only list one person or one provider/facility in this section.

Part 4. What PHI can we share?

We will only share the health information that you say is OK to share. This can be health information about your medicines. It can also be about your mental health, alcohol or drug treatment. It does not cover psychotherapy notes that <u>are not</u> in your medical file.

Part 5. Why are you giving out this PHI?

Please tell us the reason you want us to share your health information.

Part 6. When does my OK end?

You can tell us when we can no longer share your health information.

- Check the first box if you want the sharing to end after one (1) year or
- Check the second box if you want the sharing to end sooner than one (1) year. Then fill in when it should end.

Part 7. Your rights and important facts

Please read this part of the form slowly. It talks about your rights and other important facts.

Part 8. Signature of patient

This is where you sign your name and put the date you signed the form. We cannot share your health information if you do not sign the form.

Part 9. Signature of authorized representative (if any)

This section must be filled in if it is not you, the patient filling in the form.

Please Note: No personal comments of any kind from the member or person completing the AUD Form are allowed in any section of this form.