Authorization to Release Health Information (Excluding Substance Use Information) All Counties

Instructions

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 your health insurance plans should work together to provide you with the best possible care, but your providers and health plans can share only limited information without your permission. Please consider giving this permission to share information about your mental health and physical health.

What does it mean if I sign this form?
By signing this form, you are telling us that it is OK for your primary care provider, your specialists, your behavioral health care providers, your health insurance plans, or others as indicated, to share certain health information about you for the purpose of planning and coordinating your health care. This helps your providers and health insurance plans work together to take better care of you. If you do not sign this form, your benefits will stay the same. 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 managed care ID card or in your member handbook.

Why are you sharing this health information?
Sharing this information allows your providers and health insurance plans to better manage and coordinate your health care. Examples of how this information may help include: making sure the medications that you are taking are safe to take together; coordinating the health care services you are receiving; and making sure the health care you are receiving is helping to keep you healthy and well.

What health information can be shared?
Your general physical and mental health information will be shared with the providers, health plans, or other entities you have identified. This may include anything in your medical record, which may include your provider's notes, a list of your medications, or lab or test results. This will not include your behavioral health provider's notes created during a private counseling session.

> **IF** your medical records include HIV-related information, we will need your additional consent, as indicated by a separate signature in Section 4 below, to release those records.
>
> **IF** your medical records include drug and/or alcohol treatment information and you are OK with that information being shared, you must complete a separate consent that should be available from your provider.

How long does my permission to share my health information last?
Your permission will last for one year from the date that you sign this form as long as your insurance coverage remains the same. You can cancel your permission at any time. This will not take back information that was already shared, but it will stop your health information from being shared any further when sharing would require your permission. If you want to cancel your permission, you must do so by writing to the health plan that requested this form. If you physically cannot write to us, you can also cancel your permission by calling the Member Services number listed on your managed care ID card or in your member handbook.

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1. Member Information

Name: ______________________________
(last, first, middle)

MA or insurance ID: Date of birth: [ ] *(mm/dd/yyyy)* Phone: [ ] *(no dashes)*

Address: ______________________________

2. Who can release my health information?

I agree that my health information can be shared by my Physical Health Insurance Plan. ◯ Yes ◯ No

Physical Health Insurance Plan Name: ______________ Phone: [ ] *(no dashes)*

Address: ______________________________

I agree that my health information can be shared by my Behavioral Health Insurance Plan. ◯ Yes ◯ No

Behavioral Health Insurance Plan Name: ______________ Phone: [ ] *(no dashes)*

Address: ______________________________

I agree that my health information can be shared by my Primary Care Physician (PCP). ◯ Yes ◯ No

PCP Name: ______________ Phone: [ ] *(no dashes)*

Address: ______________________________

I agree that my health information can be shared by my behavioral health provider. ◯ Yes ◯ No

Name of Provider: ______________ Phone: [ ] *(no dashes)*

Address: ______________________________

I agree that my health information can be shared by "other" (please specify other, ex. Child Welfare, Juvenile Justice, etc). ◯ Yes ◯ No

Name: ______________ Phone: [ ] *(no dashes)*

Address: ______________________________

I agree that my health information can be shared by my other physical or behavioral health provider(s) below (if you have more than one physical or behavioral health provider). ◯ Yes ◯ No

Name: ______________ Phone: [ ] *(no dashes)*

Address: ______________________________

Name: ______________ Phone: [ ] *(no dashes)*

Address: ______________________________

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3. Who can receive my health information?

I agree that my health information can be shared with my Physical Health Insurance Plan. ◯ Yes ◯ No

Physical Health Insurance Plan Name: ______________________ Phone: __________ *(no dashes)*

Address: ______________________

I agree that my health information can be shared with my Behavioral Health Insurance Plan. ◯ Yes ◯ No

Behavioral Health Insurance Plan Name: ______________________ Phone: __________ *(no dashes)*

Address: ______________________

I agree that my health information can be shared with my Primary Care Physician (PCP). ◯ Yes ◯ No

PCP Name: ______________________ Phone: __________ *(no dashes)*

Address: ______________________

I agree that my health information can be shared with my behavioral health provider. ◯ Yes ◯ No

Name of Provider: ______________________ Phone: __________ *(no dashes)*

Address: ______________________

I agree that my health information can be shared with "other" (please specify other, ex. Child Welfare, Juvenile Justice, etc). ◯ Yes ◯ No

Name: ______________________ Phone: __________ *(no dashes)*

Address: ______________________

I agree that my health information can be shared with my other physical or behavioral health provider(s) below (if you have more than one physical or behavioral health provider). ◯ Yes ◯ No

Name: ______________________ Phone: __________ *(no dashes)*

Address: ______________________

Name: ______________________ Phone: __________ *(no dashes)*

Address: ______________________

I agree that my physical health plan and my behavioral health plan can both share my health information with each other. ◯ Yes ◯ No

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4. Member Signature

- Signing this authorization is voluntary. Your health plans, providers, or others as indicated, may not withhold treatment, payment, enrollment, or eligibility for benefits on whether you sign this form.
- The purpose of this authorization is to allow your health plans, providers, or others as indicated, to better manage and coordinate your care.
- This authorization will expire one year from the date that you sign this form.
- Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal or state law.
- This authorization may be revoked at any time except to the extent that the program or person who is to make the disclosure has already relied on the authorization.
- **This authorization does not include permission to share any substance use information.**
- You are entitled to a copy of this authorization in its completed form.

☐ *(Check if applicable)* I wish to exclude the following information from this disclosure (describe exclusion):

By signing below, I acknowledge that I have read and understand this form, and I give my permission to share my health information as described in this form.

Mark or signature of member | *Date*

Mark or signature of parent or legal guardian | *Date*

Relationship to member

If your records have HIV-related information, your signature below indicates that you agree that the entities or individuals named in Part 3 may share that information with each other?

Mark or signature of member | *Date*

Mark or signature of parent or legal guardian | *Date*

Relationship to member

5. Verbal Consent by Member Physically Unable to Provide Signature

☐ Check this box to indicate verbal consent given by a member physically unable to provide a signature.

☐ Check this box to indicate verbal consent given by parent/legal guardian physically unable to provide a signature.

We, the undersigned, hereby witness that the member named in Part 1 or parent/legal guardian of member, understands the nature and implications of this authorization and freely gives his/her verbal consent.

Witness 1 signature | *Witness 2 signature*

Print name | *Print name*

Date: *(mm/dd/yyyy)* | Date: *(mm/dd/yyyy)*

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6. Copy of Consent

☐ Check this box if you would like to receive a copy of this consent.

To be completed by staff member upon form completion if signed in a face-to-face meeting

The Member: ☐ Accepted ☐ Declined a completed copy of this form.

____

Signature of staff member obtaining consent

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