Last Update: February 2023

Consent to Release Protected Health Information (PHI)

Magellan Healthcare, Inc.
Attention Privacy Officer, Collaborative Care
14100 Magellan Plaza, Mail Stop MO41
Maryland Heights, MO 63043

Managing the Collaborative Care Program for:
Community Health Development, Inc.

Protected Health Information (PHI) means information about your health. Federal and state laws protect the privacy of your PHI. The laws say we cannot give anyone other than your doctors at Community Health Development, Inc. 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 Healthcare, Inc. (Magellan) at 1-800-201-3957, Option 3 **or read the separate instructions page for more information on how to complete this form.**

Part 1 Who is the patient?

Last Name	First Name	Middle Initial

ID Number	Date of Birth (MM/DD/YYYY)	Phone Number (with area code)

Address	City	State	Zip Code

Check One (to tell us who is filling out this form):

☐ I am the patient OR

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

I am his or her: ☐ Parent OR

☐ Guardian/Other (Legal Proof Required) _____

Part 2 Who can give out the PHI?

Magellan may give out your PHI. Magellan manages your mental health and/or drug and alcohol treatment through the Collaborative Care program for Community Health Development, Inc.

Part 3 Who can the PHI be given to?

Name (a person, like a family member or doctor, or a place like a clinic or hospital):	Phone Number (with area code)

Address:	City, State, and Zip Code

Part 4 What PHI can we share?

We will **only** share the PHI that you **OK.** 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 <u>are not</u> in your records. Tell us the health information from your records that can be shared. _____

_____

If you give us your **OK** to share <u>this</u> kind of health information in the above PHI, check the boxes that apply:

☐ HIV/AIDS ☐ Alcohol/Substance Abuse Records

Part 5 Why are you giving out this PHI?

Tell us why you want us to share your PHI? _____

_____

Turn this page over.

Part 6 When does my OK end?

Your **OK** will end when you tell us it does. **Tell us when you want your OK to end:**

☐ **My OK ends on this date:** _____ (It cannot be more than one year from your **OK**)

OR

☐ **My OK ends when this happens:** _____

(It can be something like "you can share my PHI this one time.") If you do not tell us when your **OK** ends, then we will end your **OK** in one year from when you sign. After one year, we will need a new **OK.**

Part 7 Your Rights and Important Facts

- Giving your **OK** is up to you. You do not have to share your information.
- You do not have to **OK** this paper. You will still get benefits and treatment.
- You can take back your **OK.** You must tell us in writing. Mail it to: Magellan Healthcare / Attention Privacy Officer, Collaborative Care / 14100 Magellan Plaza, Mailstop MO41 / Maryland Heights, MO 63043. Or you may fax it to 1-888-656-4769.
- 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.
- If we share your PHI with the people or agencies that you named, they may share it with others. Not everyone has to follow privacy rules.
- You have a right to get a copy of this signed **OK.** If you need another copy, call Magellan at 1-800-201-3957, Option 3**.**
- If you do not understand, or have questions, we can help. Call Magellan at 1-800-201-3957, Option 3.
- If you decide to complete this form and give your **OK**, send it to us at the address or fax # listed above.
- You should keep 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.

Part 8 Signature of Patient

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

_____ _____

Signature or Mark of Patient Date (required)

Part 9 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. If the patient is less than 18 years old, a parent or guardian should sign for the minor. If you have legal proof that you can act for this person, please send a copy of the proof with this form.

_____ _____

Signature of Person signing on behalf of patient Date (required)

Printed Name: _____ Phone: _____

Address: _____

NOTICE TO ANYONE OTHER THAN THE PATIENT

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.