CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

HealthChoices Integrated Care Plan Program is a program developed by the Pennsylvania Department of Human Services (DHS) to let your physical and behavioral health plans work together to help you. We can help you better if we are able to work together and with providers who know about you.

By signing this form, you are telling us it is OK for Community Behavioral Health (CBH) and your HealthChoices Physical Health Managed Care Organization (together, "the HealthChoices Integrated Care Plan Participants") and the providers listed in Part 2 below to share health information about you with each other. If you do not sign this form, your HealthChoices benefits will stay the same. These parties 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 — I say it is OK to let the HealthChoices Integrated Care Plan Program Participants and the providers listed in Part 2 below to use/disclose the PHI listed below in Part 3.

Last name, first name, middle initial:	Member ID number:
Date of birth (MM/DD/YYYY):	Phone number (with area code):
Address:	City, state, and ZIP:

Part 2 – Who can the PHI be given to?

Besides the HealthChoices Integrated Care Plan Program Participants, this information can be shared with (insert the name, address, and phone number of provider):

Primary care practitioner (PCP):	
Physical health specialty provider:	
Behavioral health provider:	
Other health care provider:	
Other health care provider:	
Physical health plan:	□ Jefferson Health Plans/Health Partners Plans □ Keystone First □ United Healthcare □ UPMC □ Geisinger □ UPMC for you CHC □ PA Health and Wellness CHC □ Keystone First CHC □ Other: _____

Part 3 – What PHI can we share?

My general physical and mental health information will be shared if I sign this form. If my records have drug and/or alcohol or HIV-related information, I want to share it with the HealthChoices Integrated Care Plan Participants and providers in Part 2 of this form, as shown below:

Drug and alcohol information (check one):

□ Yes, OK to share all drug and alcohol information. □ No, not OK to share all drug and alcohol information.

HIV/AIDS information (check one):

□ Yes, OK to share all HIV/AIDS information. □ No, not OK to share all HIV/AIDS information.

Turn This Page Over

Part 4 – Why are you giving out this PHI?

Sharing this information lets all the HealthChoices Integrated Care Plan Program Participants and the providers in Part 2 of this form work together to help me better.

Part 5 – I understand that:

I can take back my OK to share this information 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 to share this information, I must tell Keystone First. I can do it in one of these ways:

Call them at:
Community Behavioral Health Member Services
888-545-2600
TTY PA Relay, 7-1-1
Available 24/7/365

Mail to:
Community Behavioral Health
801 Market Street, 7th Floor
Philadelphia, PA 19107
ATTN: Member Services

I understand this program is about sharing my health information to help me. I also understand I will still get benefits and treatment if I do not sign this form. The information shared from this form may be shared again by those who receive it. If this happens, the information may not be protected by federal or state privacy laws. These laws do not always apply to everyone.
But if I gave my OK to share my drug and alcohol information and/or my HIV status, this information cannot be shared again unless I give another OK in writing.

Part 6 – Signature of member

My OK lasts for 2 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)

An authorized representative has legal proof that he or she can act for another person. A representative signs for a person who cannot legally sign on his or her own.

Signature of person signing on behalf of the member: _____ Date: _____

Printed name: _____ Phone: _____

Address: _____