

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 you approve 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 sharing 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 approve allowing the HealthChoices Integrated Care Plan Program Participants and the providers listed in Part 2 to use/disclose the PHI listed in Part 3.

Member Name		Member ID #	
Date of Birth		Phone	
Address		City/ST/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	<input type="checkbox"/> Jefferson Health Plans/Health Partners Plans <input type="checkbox"/> Keystone First <input type="checkbox"/> United Healthcare <input type="checkbox"/> UPMC <input type="checkbox"/> Geisinger <input type="checkbox"/> UPMC for you CHC <input type="checkbox"/> PA Health and Wellness CHC <input type="checkbox"/> Keystone First CHC <input type="checkbox"/> 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:

<input type="checkbox"/> Yes, it is OK to share all drug and alcohol information.	<input type="checkbox"/> No, it is not OK to share all drug and alcohol information.
<input type="checkbox"/> Yes, it is OK to share all HIV/AIDS information.	<input type="checkbox"/> No, it is not OK to share all HIV/AIDS information.

Part 4: Why are you sharing this PHI?

Sharing this information allows all HealthChoices Integrated Care Plan Program Participants and the providers listed in Part 2 of this form work together to assist you.

Part 5: I understand that:

I can withdrawal my approval to share this information at any time. This will not take back information already shared, but it will ensure that no additional information is shared.

If I want to take back my approval to share this information, I must inform CBH in one of these two ways:

Call:

CBH Member Services
888-545-2600
TTY PA Relay, 711
Available 24/7/365

Mail:

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

I understand this program is about sharing my PHI to assist 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.

However, if I gave my approval to share my drug and alcohol information and/or my HIV status in Part 3, this information cannot be shared again unless I give another approval in writing.

Part 6: Member signature

My approval lasts for two years from when I sign this form. It also ends if I withdrawal my approval, whichever happens first. I give my approval to share the information listed in this form.

Signature or Mark of Member: _____ Date: _____

Part 7: Signature of authorized representative (if any)

My approval lasts for two years from when I sign this form. It also ends if I withdrawal my approval, whichever happens first. I give my approval to share the information listed in this form.

Signature of Person Signing on Behalf of Member: _____ Date: _____

Printed Name: _____ Phone: _____

Address: _____

This form is provided to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This form also complies with applicable federal and state law.