AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Section 1: Member Information

(whose information is to be released?)

First Name: _____ Middle Name: _____

Last Name: _____ Date of Birth: _____

MA ID Number: _____ Phone Number: _____

Section 2: Party Receiving Health Information

(With whom are you authorizing Community Behavioral Health to share your health care information?)

Please print the name(s) of the person, provider, or organization who will be receiving your health information and their contact information.

I am requesting my own records. ☐ Yes ☐ No

Section 3: Reason For Sharing Protected Health Information

Please let us know the reason for your request ("At my request" is an acceptable answer):

Section 4: What Health Care Information Can Be Released

NOTE: Community Behavioral Health is not a Health Care Provider and does not maintain Medical Records. If you would like copies of Medical Records, please request them directly from your Health Care Provider.

To allow Community Behavioral Health to release specific types of information, you must initial your name next to the items you would like CBH to release to the parties listed in Section 2.

☐ Mental Health Information and Records Initial Here: _____

☐ Substance Use Information and Records Initial Here: _____

☐ HIV/AIDS Related Information or Records Initial Here: _____

Optional: Identify the information you are requesting.

☐ Eligibility Information	Date Range:	
☐ Claims Information	Date Range:	
☐ Service Authorization History	Date Range:	
☐ Utilization Management Notes	Date Range:	
☐ Denial Notices	List Date or Service:	

Section 5: Time Frame And Your Rights

This Authorization will remain valid for ONE YEAR or until I revoke it using the process outlined below, or until: _____

(insert expiration date or expiration event)

I understand that:

- If I want CBH to release my protected health information to another person or organization that is not listed in Section 2, I must complete a new Authorization form.
- I do not have to sign this Authorization. CBH cannot require me to sign this Authorization.
- Once CBH releases my protected health information to the person(s) listed in Section 2, the information may potentially be redisclosed by the recipient and no longer protected by the federal privacy regulations.
- I have the right to revoke this Authorization at any time, but my revocation will not affect any records that were previously disclosed. To revoke your Authorization, please send a signed and dated request in writing to the CBH Privacy Officer at 801 Market Street, 7th Floor, Philadelphia, PA 19107.

Section 6: Signature

Signature of the Member OR the Member's Legally Authorized Representative

I give Community Behavioral Health permission to release my health care information as described in this form.

X _____ Date: _____

If you are signing as the Member's legally authorized representative, you will be asked to produce appropriate legal documents granting you the authority to do so before you receive the requested records. Examples of this type of documentation include Health Care Power of Attorney, a Court Order, Guardianship documentation.