Consent for Release of Sensitive Information

This form authorizes Health Partners Plans (HPP) to use or share your health information with other health care providers/organizations. This form allows you to provide consent for the sharing of your sensitive information.

Instructions

Part 1: Your Information
This section should name the HPP member whose health information will be shared with and/or disclosed to the authorized health care provider. Print your name, birth date, address on file, telephone number and member ID number.

Part 2: Who is Authorized to Receive Your Information?
This section should list the authorized providers/organizations who will discuss your health information with HPP.

Part 3: What Information Can Be Shared?
This section should indicate what health information HPP may share with and/or disclose to the authorized providers/organizations.

Part 4: Date your authorization expires?
The authorization requires a date be given or specific event for expiration of the authorization (e.g. 1/15/2025, January/2025, or a statement "when I am no longer a member"). If there is not a date or specific event provided, the form will expire in 6 months from when signed.

Part 5: Signatures
Your signature is required. If you are incapable of signing, a personal or legal representative may sign on your behalf. Parents or guardians of minors will be confirmed using information from the state. A personal representative such as an executor or someone with a Power of Attorney may sign his or her name in the member's place. Before, the legal documents proving the authority of the personal representative on behalf of the member **MUST** be attached or on file at HPP; otherwise, the personal representative's signature will be invalid, and this form will **NOT** be processed. Other health care professionals and witnesses may need to sign this form.

Disclosure: Notice regarding Re-Disclosure and Prohibited Use of Substance Use Disorder Information

Your single consent may authorize future uses and disclosures for treatment, payment, and health care operations.
HIV/AIDS and other sexually transmitted diseases, behavioral health, genetic markers, and Substance use diagnosis, treatment, or referral for treatment from a federally assisted Part 2 program are protected by Federal confidentiality rules which prohibit any further disclosure of this information unless you obtain written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. These rules prohibit anyone from using or disclosing these records, or any testimony describing information contained in these records, in any civil, criminal, administrative, or legislative proceeding by any Federal, State, or local authority against the patient, unless authorized by the patient's written consent or as authorized by a court in accordance with Part 2. Once records are lawfully received with appropriate consent, HIPAA-regulated entities may redisclose SUD information in accordance with HIPAA, except where Part 2 provides additional protections (for example, certain counseling session notes).

Please Complete ALL sections. If information on this form is not complete, HPP will return the form and will not approve this request.

Returning the Form

Please return this form to the following address or fax it to the number listed below.

Health Partners Plans
Privacy Services
1101 Market Street, Flr 30th
Philadelphia, PA 19107

or

Fax: 267-515-6666

If you have any questions or need assistance in completing this form, call Member Relations 24/7 at 1-800-553-0784 (TTY 1-877-454-8477).
Please keep a copy of this consent and the instructions for your records.

Consent for Release of Sensitive Information

Part 1: Your Information

First Name	Last Name		Middle Initial
Member ID#	Date of Birth (MM/DD/YYYY)	Phone Number	
Address	City	State	ZIP

Part 2: Who is Authorized to Receive Your Information?

Your consent allows HPP and other health care providers you choose to share records and information about your health. Sharing information will help HPP and other health care professionals provide you with better care.

❑ **Community Behavioral Health (CBH)** 801 Market St., Philadelphia, PA 19107	❑ **Behavioral Health Managed Care Organization (BH-MCO) <u>if not CBH</u>:** Organization Name/Address/Phone Number:
❑ **Primary Care Provider (PCP)** Name/Address/Phone Number:	❑ **Behavioral Health Provider** Name/Address/Phone Number:
❑ **Physical Health Specialist** Name/Address/Phone Number:	❑ **Other Health Care Provider** Name/Address/Phone Number:

Part 3: What Information Can Be Shared?

Your physical and mental health information will also be shared if you sign this form. If your records have drug and/or alcohol treatment information, you can agree to share this information with the providers listed in Part 2 of this form.

O Yes O No Initials _____	I authorize the release of all drug and/or alcohol treatment information that is in my records to be shared with the providers listed in Part 2.
O Yes O No Initials _____	I authorize the release of any records regarding HIV-related information to be shared with the providers listed in Part 2.

Part 4: Expiration Date

This Authorization will expire on ____/____/_____ (month/day/year) OR upon the following event (e.g. "when I am no longer a member"). _____ (6months if left blank). And this consent ends if I revoke my consent (whichever comes first).

Part 5: Signatures

- I am over the age of 18 years and am knowingly and willingly making this consent.
- I consent to the release of records/information for the purpose stated above.
- I understand my consent is voluntary and not a condition of enrollment, treatment, eligibility, or claims payment.
- I understand that I may revoke this consent at any time, except to the extent information has already been released in reliance on this form.
- Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of such information and may no longer be protected by Federal or State law. Substance use disorder treatment records protected under the Federal regulations governing Confidentiality of Substance Use Patient Records, 42 CFR Part 2, may be redisclosed as permitted by Federal HIPAA law, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against me.

By signing below, you agree to share the above information. You may revoke/cancel this consent at any time by sending written notice to HPP or submitting a revocation form.

Member Name Printed

Member Signature Date

Personal/Authorized Representative (If Any): A copy of a Power of Attorney or other legal document that proves you can act for the member must be on file at Health Partners Plans or submitted with this form.

Relationship to Member

Signature of Personal Representative Telephone Number

If I am unable to sign my name below, verbally acknowledging that I have read and agree to the terms of this Authorization.

Name of Mental Health Information Witness #1 Name of Mental Health Information Witness #2

Signature Date Signature Date

Name of Drug/Alcohol Treatment Information Witness Signature Date

A copy of this form was offered to member: O Accepted O Declined