Health Partners Plans

# 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: Effective Date**
This consent shall become effective immediately and shall remain in effect from the date of signature unless a different date is specified.

**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.

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**
**HIPAA Privacy Services**
**901 Market Street, Suite 500**
**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 **1-888-477-9800** (TTY 1-877-454-8477).

***Please keep a copy of this consent and the instructions for your records.***

Health Partners Plans

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## 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 the 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.**

| | |
|---|---|
| **Behavioral Health Managed Care Organization (BH-MCO)**<br>Organization Name/Address/Phone Number: | **Behavioral Health Provider**<br>Name/Address/Phone Number: |
| **Primary Care Provider (PCP)**<br>Name/Address/Phone Number: | **Other Health Care Entity**<br>Name/Address/Phone Number: |
| **Physical Health Specialist**<br>Name/Address/Phone Number: | **Other Health Care Entity**<br>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.**

| | |
|---|---|
| ❑ Yes ❑ 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. |
| ❑ Yes ❑ 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: Effective Date

This consent shall become effective immediately and shall remain in effect until a date specified here: _____.

## Part 5: Signatures

- I am over the age of 18 years and am knowingly and willingly making this consent.
- I fully understand the above statements as they apply to me.
- I consent to the release of records/information for the purpose stated above.
- I can limit the release of certain records/information (for example, just records since 2017, records from certain doctors, etc.): _____.
- 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.
- I acknowledge I am entitled to a complete listing of disclosures including date, entity and brief description of the patient identifying information disclosed.

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) Date

_____

Member Signature

**Personal Representative Information:** A copy of a Power of Attorney or other legal document must be on file at Health Partners Plans or submitted with this form.

_____ _____

Name of Personal Representative Relationship to Member

_____ _____

Signature of Personal Representative Telephone Number

_____

Name of Mental Health Information Witness

_____

Signature Date

_____

Second Witness

_____

Signature Date

_____

Drug/Alcohol Abuse/Treatment Information Witness

_____

Signature Date

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

Disclosure: This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you 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 is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

Disclosure: Notice Prohibiting Re-Disclosure of Substance Use Disorder Information
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

Health Partners (Medicaid) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call: 1-800-553-0784 (TTY 1-877-454-8477).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-553-0784 (TTY 1-877-454-8477).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-553-0784 (телетайп 1-877-454-8477).