HIGHMARK WHOLECARE

## Consent to Release Health Information to Coordinate Physical and Behavioral Health Care

Sometimes you need to see a number of different providers to get all the services you require. This includes behavioral health providers and physical health providers. All of your providers and managed care organizations should work together to provide you with the best possible care, but your providers and managed care organizations can only talk to each other with your permission. Please consider giving this permission. Allowing your providers and managed care organizations to talk to each other about your care will help ensure that you are receiving all the care you need.

By signing this form, you are telling us that it is OK for your primary care provider, your behavioral health care providers, your physical health managed care organization and your behavioral health managed care organization to share health information about you for the purpose of planning and coordinating your health care. This helps your providers and managed care companies work together to take better care of you.

If you do not sign this form, your benefits will stay the same. Some information may still be shared even if you do not sign this consent form, but only in the way it says in the law. If you have questions about your rights or if you need more details about how your health information is shared, please call the member services number on the back of your behavioral or physical health managed care ID card or in your member handbook.

| **Part 1** | **Member Information** | | |
|---|---|---|---|
| Last Name | First Name | Middle Initial | |
| Medical Assistance ID number - MAID# (full 10-digits) | Date of Birth (MM/YYYY) | Phone Number (with area code): | |
| Address | City | State | Zip Code |

| **Part 2** | **Who can my health information be given to?** |
|---|---|

This Consent to Release Information is being requested by:

| Organization Name: | Phone Number (with area code): |
|---|---|
| Address | |

**I agree that my health information can be shared with my primary care physician (PCP) below:**

| Primary Care Provider (PCP) Name: | Phone Number (with area code): |
|---|---|
| Address | |

**Consent to Release Health Information to Coordinate Physical and Behavioral Health Care**

**I agree that my health information can be shared with my behavioral health provider below:**

| Behavioral Health Care Provider Name: | Phone Number (with area code): |
|---|---|
| Address | |

**I agree that my health information can be shared with the other physical health or behavioral health provider(s) below (if you have more than one physical health or behavioral health provider):**

| Physical/Behavioral Health Care Provider Name: | Phone Number (with area code): |
|---|---|
| Address | |
| Physical/Behavioral Health Care Provider Name: | Phone Number (with area code): |
| Address | |

**I agree that my health information can be shared with Highmark Wholecare and my Behavioral Health Managed Care Organization below. Please check your managed care organization(s):**

☐ Community Behavioral Health, Inc. (CBH)
☐ Community Care Behavioral Health Organization (CCBHO)
☐ Magellan
☐ PerformCare
☐ Beacon Health Options (Formerly Value Behavioral Health)

**I agree that my health information can be shared with Highmark Wholecare and my Community HealthChoices (CHC) below. Please check your managed care organization(s):**

☐ AmeriHealth Caritas
☐ PA Health and Wellness
☐ UPMC Community Health Choices
☐ Keystone First

## Part 3 Why are you sharing this health information?

Sharing this information allows your physical health and behavioral health managed care organizations and providers to better manage and coordinate your health care. While the health care plan developed will be unique to your own needs, some common goals include, but are not limited to: (1) making sure the medications that you are taking are safe to take together; (2) coordinating the health care services you are receiving; and (3) making sure the health care you are receiving is helping keep you healthy and well.

## Part 4 What health information can we share?

My general physical health information will be shared if I sign this form.

Some information requires special permissions to release. I am OK with the following information being shared:

## Consent to Release Health Information to Coordinate Physical and Behavioral Health Care

☐ Pregnancy
☐ Family Planning
☐ Mental/Behavioral Health
☐ Developmental Disabilities
☐ HIV/AIDS Testing or Treatment
☐ Sexually Transmitted Disease
☐ Alcohol and/or drug abuse

Do not check any of the boxes if you are not OK with sharing any of the information listed above

### Part 5 I understand that:

I can take back or cancel my permission (OK) on this consent form at any time. This will not take back the information that was already shared, but it will make sure no more of my medical information is shared. If I want to take back my permission (OK), I must tell the organization who requested this form from Part 2 above. I can call the member services number on the back of my behavioral or physical health managed care ID card or in my member handbook.

### Part 6 Signature of Member

- Even if I do not sign this form, I will still get the benefits and treatment I need.
- My medical information that is shared because I sign this form may be shared again by those who receive it. In the event there is drug and/or alcohol treatment information or HIV-related information in my records, that information cannot be shared with anyone unless I give my permission (OK) in writing again.
- My permission (OK) lasts for two (2) years from the date I sign this form. I may cancel my permission at any time by calling the member services number on the back of my behavioral or physical health managed care ID card or in my member handbook.

I give my permission (OK) to share the information listed on this form.

_____ _____
Signature or mark of Member Date

**If the member is under the age of 18, the member's parent/guardian also needs to provide consent:**

_____ _____
Signature or mark of Member's Parent/Guardian Date

## Consent to Release Health Information to Coordinate Physical and Behavioral Health Care

**Part 7 Signature of Authorized Representative (if any)**

If this consent form is signed by someone who is not the member listed at the beginning of this consent form, attach any documents (e.g. general power of attorney) that verifies the signer's legal authority to act for and on behalf of the member.

_____ _____
Signature of person signing on behalf of member Relationship to member

_____ _____
Printed Name Date

Address: _____

_____

Phone: _____

Witness: _____ _____
Signature Date

Printed Name: _____

We comply 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.

We do not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

We provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

We provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Highmark Wholecare at 1-800-392-1147

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

Highmark Wholecare
Member Appeals,
P.O. Box 22278
Pittsburgh, PA 15222
1-800-392-1147, [TTY/PA Relay 711],
Fax # (844)325-3435

The Bureau of Equal Opportunity,
Room 223, Health and Welfare Building,
P.O. Box 2675,
Harrisburg, PA 17105-2675,
Phone: (717) 787-1127, TTY/PA Relay 711,
Fax: (717) 772-4366, or
Email: RA-PWBEOAO@pa.gov

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, Highmark Wholecare and the Bureau of Equal Opportunity are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW.,
Room 509F, HHH Building,
Washington, DC 20201,
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call: 1-800-392-1147 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-392-1147 (TTY/PA RELAY: 711)**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-392-1147 (телетайп/PA RELAY: 711)**.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電**1-800-392-1147 (TTY/PA RELAY：711)**。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-392-1147 (TTY/PA RELAY: 711)**.

**1-** ةظوحلم: اذإ تنك تدحتت ركذا ةغلل، نإف تامدخ ةدعاسلا ةيوغللا رفاوتت لكل ناجملاب. لصتا مقرب **800-392-1147** (مقر فتاه مصلا مكبلاو: 711 ).

यान ि दनह स:
तपाइर ्ंल न पाल ब नुह ु छ भन तपाइर ्ंक ि नि त भाष ा सहायत ा स वाह ि नःशु क
पम ा उपल ध छ । फ न गनुह स **1-800-392-1147 (ि टिि व इ/PA RELAY: 711)** ।

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-392-1147 (TTY/PA RELAY: 711)** 번으로 전화해 주십시오.

របយ័តន៖ េបើសនជាអនកនិយាយ ភាសាែខមរ, េសវាជំនួយែផនកភាស
ឥតគិតឈន ួល
គឺអាចមានសំរាប់ នក។ ចូរ ទូរស័ពទ **1-800-392-1147 (TTY/PA RELAY: 711)**។
ប ំេរ

ATTENTION :Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le **1-800-392-1147 (ATS/PA RELAY 711)**.

သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊
သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ **1-800-392-1147** (TTY/PA RELAY: 711)
သုိ႔
ေခၚဆိုပါ။

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-392-1147 (TTY/PA RELAY: 711)**.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-392-1147 (TTY/PA RELAY: 711).**

লkয্ ক নঃ যিদ আযিন ব াংলা , কথ বললত ি লারন, ত লেল যানঃখরচ য় ভ ষ সে য়ত যিলরষব uিলb আআছ।
আাফ ন ক ন **1-800-392-1147 (TTY/PA RELAY: 711)**

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në **1-800-392-1147 (TTY/PA RELAY: 711)**.

ચના: જો તમો જરાતો બ લતા હો , તો િોન: ક ભાષો। સહાય સો વાઓ તમારો। માટ ઉપલ ધ છો . ફ ન કર 1-800-392-1147 (TTY/PA RELAY: 711).