Consent to Release Protected Health Information (PHI)

Magellan Entity: Magellan in Wyoming

Street Address: P.O. Box 1963

City, State, Zip Code: Evanston, WY 82931

Account Name and Phone #: Managing Care for Wyoming Medicaid - 1-866-571-0944

Protected Health Information (PHI) means information about your health. Federal and state laws protect the privacy of your PHI. These laws say we cannot give your PHI to anyone other than your doctors or Wyoming Medicaid unless you say it is OK. By signing this paper, you give us your OK. We will only give out the PHI that you say we can share. And, we will only give it to the people or agencies that you list. Do you have questions? We can help. Call us at 1-855-883-8740.

1 **Member**	**Last Name**	**First Name**			**Middle Initial**
	Date of Birth	**ID Number from Your ID Card**		**Phone Number**	
	Street Address	**City**	**State**	**Zip Code**	

Please check ONE:

☐ **I am the member – OR --**

☐ **I have the legal right to act for this person. (Check on below; if "other" fill in the blank)**

I'm their: ☐ **Parent OR** ☐ **Guardian OR** ☐ **Other** _____

2 **Who can release the PHI?**	Magellan Health, Inc. may give out your PHI. Magellan Health, Inc. manages your mental health and/or drug and alcohol treatment for Wyoming Medicaid.				
3 **Who can the PHI be given to?**	**Name** (individual or class of persons like "family members residing with me")		**Organization (if applicable)**		
	Street Address	**City**	**State**	**Zip Code**	**Phone Number**

(TURN OVER IF PRINTED)

4 **What PHI can we share?**	We will only share the PHI that you OK. This OK includes facts about your medicine. It also includes facts about your mental health and/or your alcohol and drug treatment that are in your records. It does not cover psychotherapy notes that are not in your medical records. Please be specific and tell us the health information from your records that can be shared. Please provide dates and places of service for the information you are requesting to be released.
5 **What is the Purpose for the Release?**	**Tell us why you want us to share your PHI.**
6 **When does this OK end?**	**Your OK will end when you tell us it does. Tell us when you want your OK to end:** ***Please check one:** ◯ **My OK ends on _____** **(Note: It cannot be more than one year from your OK.)** **--OR--** ◯ **My OK ends when: _____** **(It can be something like "You can share my counseling records this one time" and it needs to happen within one year from when you sign this form.)** **If you do not tell us when your OK ends, then we will end your OK one year from when you sign this form. After one year, will need a new OK from you.**
7 **Your Rights & Important Facts**	• Giving your OK is up to you. You do not have to share your information. • You do not have to OK this paper. You will still get benefits and treatment. • You can take back your OK. You must tell us in writing. Mail it to the address listed in Section 10 below. • What if you take back your ok? This will not take back the PHI that we have already shared. But, we will not share any more of your PHI. • If we share your PHI with the people or organization(s) that you named, they may share it with others. Not everyone has to follow privacy rules. • You have a right to get a copy of this signed OK. If you need another copy, please call Magellan at the phone number listed in Section 10 below. • If you do not understand anything on this form or if you have questions, we can help. Please call the phone number listed in Section 10 below.

A SIGNATURE AND DATE ARE REQUIRED IN EITHER SECTION 8 OR 9 BELOW		
8 **Member Signature**	I give my OK to share the information listed in this paper. **Signature or Mark (Required):** _____	**Date (Required):** _____
9 **Authorized Representative Signature**	Authorized Representative means you have legal proof that you can act for this person. If the member is less than 18 years old, a parent or guardian should sign for the minor where state law allows.	
	Signature (Required): _____ **Printed Name:** _____	**Date (Required):** _____ **Phone Number:** _____
	Please tell us your legal proof to act for this person. We may ask you to send us proof. _____	
10 **Where to Send this Form & Ask Questions (MAGELLAN USE ONLY)**	After you fill in and sign this form, send it to us at the address below. If you have any questions about how to complete this form, the ways to contact us are below. You should get a copy of this form. Remember, PHI means information about your health in the past, present, or future. It includes facts like your address and date of birth too. A full definition of PHI is at 45 CFR 160.103.	
	Mailing Address Magellan of Wyoming PO Box 1963 Evanston, WY 82931	**Email Address** WyomingInfo@MagellanHealth.com
	Phone Number: (855) 883-8740	**Fax Number:** (888) 656-2597

NOTICE TO RECIPIENT OF INFORMATION

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is 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