Commonwealth of Pennsylvania, Department of Public Welfare
Authorization for Use or Disclosure of Protected Health Information

Please fill out this form. The form has two parts.

Part A should be filled out and signed for each child.

Part B should be filled out and signed if your child's health records include information about:

The use of drugs or alcohol
Mental Health
HIV/AIDS

Signing this form will let CHIP and your child's doctors share your child's health information with Medical Assistance and the Department of Public Welfare (DPW). DPW will use the information to see if your child can get Medical Assistance.

PART A-General Information

This authorization ends 3 months from the date it is signed.

1. I give my permission to any and all health care providers who have treated my child to share the medical records of my child to the Pennsylvania Department of Public Welfare and <the CHIP Insurance contractor> (the "Department" and the "CHIP Contractor") from the records of:

Name: _____

Date of birth: _____

Telephone: _____

Address: _____

City _____ State _____ Zip _____

Social Security Number _____

Health Insurance ID number _____

2. The medical records will be shared so that the Department may review them to see if children currently enrolled in CHIP may qualify for Medicaid. Medical records disclosed should be those related to [insert description of child's condition here] _____.

3. I understand that:

a. this authorization may be revoked at any time by writing to CHIP or the CHIP Contractor or the Department, except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.

b. signing this form may be required so that my child can continue to stay on CHIP.

c. information (except drug and alcohol information) disclosed pursuant to this authorization may be subject to redisclosure by the individual/organization identified in section A (1st page) and if so, would no longer protected by federal privacy regulations.

d. CHIP, the CHIP Contractor, the Department, its programs, services, employees, officers and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

_____ _____

Signature of Parent/Legal Guardian Date

Tell us your relationship to the child

_____

PART B – Special Categories of Medical Information

B.1 Drug and Alcohol Information

If my medical record includes drug and alcohol information, I want to send that information to the Department and the CHIP Contractor.

_____ Yes _____ No

This information will be disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit the individual/organization identified in Part A of this form 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 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. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

B.2 Mental Health Information

If my medical record includes mental health information, I want to send that information to the Department and the CHIP Contractor.

_____ Yes _____ No

B.3 HIV/AIDS Information

If my medical record includes HIV/Aids information, I want to send that information to the Department and the CHIP Contractor.

_____ Yes _____ No

This information will be disclosed from records protected by Pennsylvania law. Pennsylvania law prohibits further disclosures 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.

For mental health information, a child age 14 or older can sign this consent

_____ _____
Signature of Child age 14 or older (for mental health consent only)

_____ _____
Signature of Parent/Legal Guardian (for mental health, HIV, and/or drug and alcohol consent)

Tell us your relationship to the child
_____ Date _____

_____ _____
Signature of Witness Date
(necessary for release of mental health and drug and alcohol information)

If individual is physically unable to sign, signature of second witness:

_____ _____
Signature of Witness Date