PA 1723 Instructions for Completion

CASE IDENTIFICATION	
CO	RECORD NUMBER

This form should be completed by the County Assistance Office (CAO) or Authorized Agent. An Authorized Agent is a case manager from a DHS contractor, who is initiating the need for the client's authorization for consent of Maximizing Participation Project (MPP) purposes for service provision and eligibility for Extended TANF (ETANF). All demographic information should be completed. This form must be scanned into the individual's DHS case record. The Authorized Agent must ensure this form is provided to the CAO upon completion.

1. **I authorize the Department of Human Services and Authorized Agent(s) to use/disclose individual information as described below from the records of:**

   Name: _____
   Date of Birth: _____ Telephone: _____
   Address: _____
   ID number(s) (identify each type of number) _____
   _____

2. **Reason for disclosure: I understand the reason for disclosure is to acquire MPP services and maintain MPP eligibility:** MPP eligible individual must initial _____

3. **I understand that:**

   a. this authorization may be revoked at any time by writing to the individual/organization identified in section 1 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. the Department and its health and human services programs will not condition treatment, payment, enrollment, or eligibility on the provision of this authorization.

   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.2 below and is no longer protected by federal privacy regulations.

   d. 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.

   e. I may refuse to sign this authorization.

PART A - General Information

A.1 Information to be disclosed and period of information requested (Identify specifically the information to be used/disclosed such as welfare records, lien records, inspection records, etc. If information to be used or disclosed includes mental health, drug and alcohol, or HIV-related information, please complete section of this form that relates to that information:

_____

A.2 This information is to be disclosed to (Please ensure all MPP Team Members are listed individually):

_____
(Insert name or title of the individual/organization to whom disclosure is to be made)

A.3 The PA 1723 attachment Coordination of Care: Clinical Profile is only to be used when needed to obtain clinic information on a client's current medical treatment for the purpose of service provision and eligibility as it pertains to MPP and when needed to obtain clinical information of the client's current medical treatment. This authorization expires as indicated:

_____ Once Acted Upon

_____ Other (specify date or event): _____

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 individual/organization identified in Part A of this form.

_____ Yes _____ No or Not Applicable

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 dis closure 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

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B.2 Mental Health Information

If my medical record includes mental health information, I want to send that information to the individual/organization identified in Part A of this form.

_____ Yes _____ No or Not Applicable

B.3 HIV/AIDS Information

If my medical record includes HIV/Aids information, I want to send that information to the individual/organization identified in Part A of this form.

_____ Yes _____ No or Not Applicable

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.

* *

PA 1723 Signatures

_____ _____
Signature of Individual Date

_____ _____
Signature and Relationship of Personal Representative Date

_____ _____
Signature of CAO Worker or Authorized Agent Witness Date

_____
Agency

COORDINATION OF CARE: CLINICAL PROFILE

NAME OF MEMBER/PATIENT/CLIENT:

TYPE AND DATES OF TREATMENT:

DIAGNOSTIC SUMMARY (INCLUDE CURRENT DIAGNOSIS AND DATES, IF KNOWN):

1.	2.
3.	4.

TREATMENT SPECIAL CONCERNS:

MEDICATIONS (CURRENT):

RELEVANT PAST MEDICATIONS:

LABORATORY TESTS (NOTE UNUSUAL OR SIGNIFICANT FINDINGS):

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY STATE CONFIDENTIALITY RULES (MH PROCEDURES ACT OF 1976, AS AMENDED). THE STATE RULES PROHIBIT 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 AS OTHERWISE PERMITTED BY MH PROCEDURES ACT OF 1976, AS AMENDED. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. THE STATE RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY MENTAL HEALTH PATIENT.