PA 1723 Instructions for Completion

The top of Page 1 should be completed by the MPP Case Manager or Authorized Agent such as the BETP contractor (MPP, SPOC, Supported Work, etc.), who is initiating the need for the client's authorization for consent. All demographic information should be completed.

Part A - Authorization

Section 1:

List the agencies and individuals to whom the client is giving permission to release information and who are being permitted to receive this information. It is important to be specific. (MPP Team members should be individually identified, yet can be listed on the same line.)

Section 2:

If the participant intends to also give reciprocal permission to someone releasing information to also receive information, the agencies and individuals to whom permission is being given to release and receive information should be listed in section 2. For various reasons, some agencies and individuals may not be reciprocal.

Example:

Section 1:	From:	CAO	To:	IMX (WCA contractor)
	From:	Dr. Smith	To:	IMX (WCA contractor)
	From:	CAO	To:	MPP Team members (please specify)
Section 2:	From:	IMX (WCA contractor)	To:	CAO and MPP Team and Dr. Smith
	From:	MPP Team members (please specify)	To:	CAO

NOTE: The list of agencies and individuals who are being given authorization to disclose information is the client's choice.

Indicate the reason(s) the client is choosing to disclose information.

Part B - Information to be Disclosed

The MPP participant (or potential MPP participant) must initial next to each selection that is applicable. Only the information that has been initiated can be released.

B.1 Information that is to be disclosed must be identified in the section. For example: medical records, DHS case records, etc.

B. 2 Authorization start and end date must be completed (a maximum 12 month period of time).

Sections B3, B4 & B5 coincide with the information checked under "Information to be Disclosed." For instance, if Mental Health is not checked, the answer to B.4 would be No.

Signatures and Disbursement

The MPP participant and MPP Case Manager or Authorized Agent must sign the form. If Drug and Alcohol or Mental Health information is to be released, a witness must also sign the form. If the MPP participant is unable to sign the form, then a second witness signature is required.

The Original Copy should be maintained in the MPP case record.

Coordination of Care: Clinical Profile (1723 Attachment)

This attachment was originally included on the reverse side of the PA 1731 and PA 1732. It is to be used only when needed to obtain clinical information on a client's current medical treatment.

Commonwealth of Pennsylvania Department of Human Services

Authorization for Release of Information

Date _____ County _____ County/Record Number _____

MPP Caseworker or Authorized Agent _____ Phone # _____

CAO or Authorized Agency _____

Client Name: _____ Date of Birth: _____

Address: _____ Social Security # _____

PART A-Authorization

I authorize my information to be released and disclosed:

1. From:	**To:**
_____	_____
_____	_____
_____	_____
_____	_____

2. From:	**To:**
_____	_____
_____	_____
_____	_____
_____	_____

Reason for disclosure:
___ **to receive services** ___ **referrals** ___ **waivers of requirements** ___ **other (please specify)** _____

PART B - Information to be Disclosed (Individual must initial beside each selection)

_____ General Health Information _____ Mental Health _____ Drug & Alcohol _____ HIV _____ Domestic Violence

B.1 **Information to be disclosed (Identify specifically the information to be used/disclosed. If information to be used or disclosed includes mental health, drug and alcohol, or HIV-related information, please complete Part B of this form that relates to that information):**

B.2 **This authorization expires as indicated:**

From _____ to _____ but not to exceed twelve months from the date of the individual's signature on page 2, unless otherwise revoked in writing.

B.3 Drug and Alcohol

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 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.4 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.5 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.

I understand that:

- ✓ this consent is voluntary. I may refuse to sign this form.
- ✓ this authorization may be revoked at any time by writing to the individual(s)/organization(s) identified in this authorization 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.
- ✓ the department and its health and human services programs will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.
- ✓ information (except drug and alcohol information) disclosed pursuant to this authorization may be subject to redisclosure by the individual(s)/organization(s) identified in this authorization below and is no longer protected by federal privacy regulations.
- ✓ 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.
- ✓ none of the information released will be used to support any criminal charges or conduct in an investigation of me, without a court order
- ✓ if I do not sign this form, my doctor may not receive information that could be important to my treatment.

_____ _____
Signature of Individual Date

_____ _____
Signature of CAO Worker or Authorized Agent Witness Date

_____ _____
Signature of Parent/Guardian if individual is a minor. Date

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

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.