



# Authorization for Use or Disclosure of Protected Health Information

**Please fill out this form. This form has two parts.**

Part A should be filled out 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 the Children's Health Insurance Program (CHIP) and your child's doctors share your child's health information with Medical Assistance. The Department of Human Services (DHS) will use this information to see if your child can get Medical Assistance.

## **PART A - General Information**

**This authorization ends three months from the date it is signed.**

- A1.** I give my permission to any and all health care providers who have treated my child to share the medical records of my child with DHS and (the "CHIP contractor") from the records of:

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

HEALTH INSURANCE ID NUMBER: \_\_\_\_\_

- A2.** The medical records will be shared so that DHS may review them to see if children currently enrolled in CHIP may qualify for Medical Assistance. Medical records disclosed should be those related to:

**A3.** I understand that:

- a. This authorization may be revoked at any time by writing to CHIP or the CHIP contractor or DHS, 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 Part A (1st page) and, if so, would no longer be protected by federal privacy regulations.
- d. CHIP, the CHIP contractor, DHS, 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.

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Signature of Parent/Legal Guardian

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Date

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Relationship to the Child



## **PART B - Special Categories of Medical Information**

**This authorization ends three months from the date it is signed.**

### **B1. Drug and Alcohol Information**

If my medical record indicates drug and alcohol information, I want to send that information to DHS and the CHIP contractor.

☐ YES ☐ NO

This information will be disclosed from records protected by the 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.

### **B2. Mental Health Information**

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

☐ YES ☐ NO

### **B3. HIV/AIDS Information**

If my medical record includes HIV/AIDS information, I want to send that information to DHS 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)

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to the Child

\_\_\_\_\_  
Signature of Witness (necessary for release of mental health and drug and alcohol information)

\_\_\_\_\_  
Date

\_\_\_\_\_  
If individual is physically unable to sign, Signature of Second Witness

\_\_\_\_\_  
Date