MBHP
Massachusetts Behavioral Health Partnership
A Carelon Behavioral Health Company

Authorization for MBHP/Carelon Behavioral Health to Release Confidential Information

Important: By completing all sections of this form you allow the Massachusetts Behavioral Health Partnership (MBHP)/Carelon Behavioral Health (Carelon) to disclose healthcare information to the individuals you identify for up to one year. You may allow MBHP/Carelon to share healthcare information with your family, providers, legal representative, or **anyone** you wish to have access. Please fill in all sections as incomplete forms may be returned.

Please note: It is also important for your doctor to have access to your medical information to ensure you receive the best care possible, including any follow-up care that may be needed. To allow MBHP/Carelon the ability to send your healthcare information to your doctor, complete and sign this form. We will only send information that pertains to your care.

If your request involves alcohol or substance use disorder information, please pay attention to the special instructions in the applicable sections.

Section 1: Whose Healthcare Information is to be Released?

I**,**____**(Member Name)** authorize MBHP/Carelon (or any Carelon Behavioral Health subsidiary holding my information) to disclose my healthcare information as described below.

Additional Member Identifying Information

Member ID#:____________________________ DOB:___/___/______

Phone Number:_____________________ Name of Health Plan: _______________________

Section 2: Who is to Receive this Healthcare Information?

Print the name(s) of person, provider, or entity who will be receiving your information and contact information (if known):

____

____

____

Phone number of who will be receiving your information: ____________________________________

Is it ok to include information from past, present, and/or future treating provider(s)?:

☐ Yes ☐ No

Section 3: Why Should this Healthcare Information be Released?

Reason ("At my request" is an acceptable response): ____________________________________

____

Specify, if possible:

☐ Care Coordination/Management ☐ Claim Assistance

☐ Quality of Care Review ☐ Other (please explain reason): ________________

Section 4: What Healthcare Information May be Released?

By initialing the items on the following page, you authorize MBHP/Carelon to release specific types of

information to the party identified in Section 2 above:

________Mental health information and/or records **(INITIALS REQUIRED)**

________Alcohol or substance use disorder information and/or records **(INITIALS REQUIRED)**

Optional:	☐ Claims info ☐ Authorizations ☐ Explanation of benefit ☐ Denials/Appeals info ☐ Clinical notes

________HIV/AIDS-related information and/or records **(INITIALS REQUIRED)**

________Other health information, please specify **(INITIALS REQUIRED)**: ____________________
Special instructions, if any (you may specify provider, date span, service type, etc.):

____

Section 5: How Long Should this Authorization Last?

This authorization shall be in force and effect **for one year** or until I revoke it, in the manner described below or until **(insert expiration date or event)** __________*(whichever is shorter).*

Section 6: What Are My Rights?

- You have a right to request a copy of this form and to request a copy of the information that is being disclosed.
- You do not have to sign this authorization, and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits.
- The information disclosed by this authorization may be at risk for re-disclosure by the recipient and if that happens, it might no longer be protected by federal privacy laws.
- You have a right to revoke this authorization at any time. ***But if you revoke this authorization, the revocation will not affect the disclosure of any information that MBHP/Carelon has already sent to the recipient.***
- If you authorized release of alcohol or substance use disorder information to a healthcare organization that is not your treating provider, for the next two years, you have the right to find out who within that organization actually saw your information. You should contact the organization directly for that information.

Please note that if you have authorized the release of ONLY alcohol or substance use disorder treatment records, you may revoke this authorization verbally. Revocation involving all other types of healthcare records must be in writing.

____ ______________________
Signature of the Member or the Member's Legally Authorized Representative* Date

____

Print Name

*** NOTE:** *If you are signing as the individual's Legally Authorized Representative, attach a copy of the appropriate legal document(s) granting you the authority to do so. Examples would be a* ***healthcare*** *power of attorney, a court order, guardianship papers, etc.* ***A financial or business power of attorney is NOT sufficient.***

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Please contact us at 1-800-495-0086 with any questions or to determine where to mail or fax your request.

MBHP complies with applicable federal civil rights laws and does not discriminate, exclude, or treat people differently because of race, color, national origin, ancestry, age, disability, religious creed, sex, sexual orientation, gender identity, gender stereotyping, genetic information, or veteran status. MBHP's notice of non-discrimination can be found at h*ttp://www.masspartnership.com/member/NonDiscriminationNotice.aspx.*

You can get this information in other languages and other formats, such as large print or Braille.

Call us at 1-800-495-0086 from Monday to Thursday, 8 a.m. to 5 p.m. and Friday 9:30 a.m. to 5 p.m. The call is free! Call TTY 1-877-509-6981 if you are deaf, hard of hearing, or speech impaired.

Tenemos información en español. Servicio de intérpretes gratis!