



Authorization for Release of Protected Health Information – Behavioral Health Home Services

BEHAVIORAL HEALTH HOME NAME	HEALTH PLAN NAME (if enrolled)
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Your behavioral health home (BHH) services provider is listed above. The BHH provider will work with you and the people you want to help you to coordinate the care that you receive under Minnesota Medical Assistance (MA). This includes the services that are managed by your health plan and the services that you receive from providers that you list below. In order to do this, the BHH provider needs to share your protected health information (PHI). PHI is your health information that is protected by federal and state law.

By signing this form, you are telling the BHH provider that it is okay for the provider and the health care providers and people listed in Part 3 of this form to share your PHI with each other. You can choose not to give your permission to share your PHI. If you choose not to give your permission, it will affect your behavioral health home services. Your other Medical Assistance benefits will stay the same. Your health care providers may still share your PHI even if you do not sign this form, but only in the way that federal or state law allows. If you have questions, please ask the person who gave you this form to tell you about your rights or more details about how your health information is shared.

Part 1 - Who is the participant?

I say it is okay for my behavioral health home provider to share the health information listed in Part 2 with my health plan (if I am enrolled in one) and the health care professionals and people I have listed in Part 3.

PARTICIPANT LAST NAME		PARTICIPANT FIRST NAME		MIDDLE INITIAL
PARTICIPANT ADDRESS		CITY	STATE	ZIP CODE
PARTICIPANT MHCP MEMBER ID	PARTICIPANT PHONE NUMBER		PARTICIPANT DATE OF BIRTH (MM/DD/YYYY)	

Part 2 - What protected health information (PHI) can your providers share?

Information about my general physical and mental health and about community supports and services will be shared with my behavioral health home provider, my health plan (if I am enrolled in one) and all the health care providers and people listed below in Part 3. This includes information about my medications and any communicable disease (for example, hepatitis) that I might have. It also includes facts about my mental health and alcohol and drug treatment that might be in my records. This does not cover psychotherapy notes that are not in my medical record or psychological testing material. **IF** my records have drug or alcohol information, I want to share that information as shown below:

Drug and Alcohol Information – **IF** my records have drug and alcohol information, I want to share it with the BHH provider listed at the top of this form, the health plan listed at the top of this form and the health care providers and people listed in Part 3 below.

Yes, all drug or alcohol information can be shared.

Part 3 - Who can my PHI be given to?

Besides the BHH provider and the health plan (if enrolled) listed at the top of this form, my health information may also be shared with the following health care providers or people: (copy this page before entering information if you want to list more than five names)

PROVIDER GROUP NAME OR PERSON'S NAME		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

PROVIDER GROUP NAME OR PERSON'S NAME		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

PROVIDER GROUP NAME OR PERSON'S NAME		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

PROVIDER GROUP NAME OR PERSON'S NAME		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

PROVIDER GROUP NAME OR PERSON'S NAME		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

Part 4 - Why are you giving out my PHI?

I am agreeing to share my PHI with my behavioral health home team, my health plan (if I am enrolled in one) and the other health care providers and people that I have listed in Part 3 so they can make sure that my treatments, medications and services work together and help me reach my health and wellness goals.

Part 5 - Your rights and important facts

- It is my decision whether I give permission to share my PHI. I do not have to share my health information. But if I don't agree to share my health information, I understand that the behavioral health home services available to me will be very limited.
- I may stop this authorization with a written notice at any time, but this written notice will not affect the information my behavioral health home services provider has already requested.
- I do not have to sign this form. If I decide to stop participating in BHH services, I will continue to get all of my other MA-covered health care services.
- If I want to take back my permission, I must tell my BHH provider listed at the top of this form. I need to do this in writing. If I need assistance with this process, I can call the DHS Member Help Desk at 651-431-2670 or 800-657-3729.
- Information that is shared from this form may be shared again by those who receive it. If this happens, it may not be protected by federal or state privacy laws. These laws do not always apply to everyone. But my drug and alcohol information cannot be shared outside of my behavioral health home providers unless I give my permission again in writing.
- If I do not understand or if I have questions, I can get help by calling the DHS Member Help Desk at 651-431-2670 or 800-657-3729.

Part 6 – When does my permission to share my PHI end?

My permission to share my PHI lasts from when I sign this form until I am no longer participating in BHH services. It also ends if I take back my permission. If I have a break in my Medical Assistance coverage and I fix this break within ninety days, I understand that I will still be with the BHH provider listed at the top of this form. I understand that if I stop being part of the BHH provider listed at the top of this form my information can be shared between my providers for up to sixty days so that they can be working together on my care even if I am not covered by Medical Assistance anymore.

Part 7 – Signature of BHH participant

I give my permission to share my PHI as described in this form.

SIGNATURE	DATE
SIGNATURE OF PARTICIPANT'S PARENT	PRINTED NAME OF BHH PARTICIPANT

800-657-3739

Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໂປຣດຊາບ. ຖ້າທາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la' aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

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ADA1 (9-15)



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