Jefferson Health Plans

Consent for Release of Sensitive Information

This form authorizes Jefferson Health Plans to use or share your health information with other health care providers/organizations. This form allows you to provide consent for the sharing of your sensitive information.

Instructions for Completing this Authorization Form

Part 1: Your information. This section should name the Jefferson Health Plans member whose health information will be shared with and/or disclosed to the authorized health care provider. Print your name, birth date, address on file, telephone number and member ID number.

Part 2: Who is authorized to receive your information? This section should list the authorized providers/organizations who will discuss your health information with Jefferson Health Plans.

Part 3: What information can be shared? This section should indicate what health information Jefferson Health Plans may share with and/or disclose to the authorized providers/organizations.

Part 4: Expiration date. The authorization requires a date be given or specific event for expiration of the authorization (e.g. 1/15/2026, January/2026, or a statement "when I am no longer a member"). If there is not a date or specific event provided, the form will expire in 6 months from when signed.

Part 5: Signatures. The *member's* signature is required. If the member is incapable of signing, a personal or legal representative may sign on the member's behalf. Parents or guardians of minors will be confirmed using information from the state. A personal representative such as an executor or someone with a Power of Attorney may sign his or her name in the member's place. The legal documents proving the authority of the personal representative on behalf of the member **MUST** be attached or on file at Jefferson Health Plans; otherwise the personal representative's signature will be invalid and this form will **NOT** be processed.

Disclosure: Notice regarding Re-Disclosure and Prohibited Use of Substance Use Disorder Information

Your single consent may authorize future uses and disclosures for treatment, payment, and health care operations. HIV/AIDS and other sexually transmitted diseases, behavioral health, genetic markers, and Substance use diagnosis, treatment, or referral for treatment from a federally assisted Part 2 program are protected by Federal confidentiality rules which prohibit any further disclosure of this information unless you obtain written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. These rules prohibit anyone from using or disclosing these records, or any testimony describing information contained in these records, in any civil, criminal, administrative, or legislative proceeding by any Federal, State, or local authority against the patient, unless authorized by the patient's written consent or as authorized by a court in accordance with Part 2. Once records are lawfully received with appropriate consent, HIPAA-regulated entities may redisclose SUD information in accordance with HIPAA, except where Part 2 provides additional protections (for example, certain counseling session notes).

Complete ALL sections. If information on this form is not complete Jefferson Health Plans will return the form and will not approve this request until it is completed in full.

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Contact Information

RETURN YOUR FORM(S) TO THE ADDRESS OR FAX NUMBER LISTED BELOW.

If you have any questions or need assistance in completing this form, call the Member Relations telephone number on the back of your identification card or write to:

Jefferson Health Plans
Privacy Services
1101 Market Street, Suite 3000
Philadelphia, PA 19107
or Fax: 267-515-6666

Please keep a copy of this Authorization and the instructions for your records

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Consent for Release of Sensitive Information
All fields are required.

1. Your information	
Member Name:	**Date of Birth:**
Address:	**City/ZIP:**
Member ID #:	**Telephone:**

2. Who is authorized to receive your information?	
Your consent allows Jefferson Heath Plans and other health care providers you choose to share records and information about your health. Sharing information will help Jefferson Heath Plans and other health care professionals provide you with better care.	
☐ **Community Behavioral Health (CBH)** 801 Market St., Philadelphia, PA 19107	☐ **Behavioral Health Managed Care Organization (BH-MCO) <u>if not CBH</u>:** Organization Name/Address/Phone Number:
☐ **Primary Care Provider (PCP)** Name/Address/Phone Number:	☐ **Behavioral Health Provider** Name/Address/Phone Number:
☐ **Physical Health Specialist** Name/Address/Phone Number:	☐ **Other Health Care Provider** Name/Address/Phone Number:

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3. What information can be shared?

Your physical and mental health information will also be shared if you sign this form. If your records have drug and/or alcohol treatment information, you can agree to share this information with the providers listed in Part 2 of this form.

☐ Yes	☐ No	Initials _____	I authorize the release of all drug and/or alcohol treatment information that is in my records to be shared with the providers listed in Part 2.
☐ Yes	☐ No	Initials _____	I authorize the release of any records regarding HIV-related information to be shared with the providers listed in Part 2.

4. Expiration date

This Authorization **will expire** on __ / __ / ____ (month/day/year) **OR** upon the following event (e.g., "when I am no longer a member"). _____

5. Signatures

- I am over the age of 18 years and am knowingly and willingly making this consent.
- I consent to the release of records/information for the purpose stated above.
- I understand my consent is voluntary and not a condition of enrollment, treatment, eligibility, or claims payment.
- I understand that I may revoke this consent at any time, except to the extent information has already been released in reliance on this form.
- Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of such information and may no longer be protected by Federal or State law. Substance use disorder treatment records protected under the Federal regulations governing Confidentiality of Substance Use Patient Records, 42 CFR Part 2, may be redisclosed as permitted by Federal HIPAA law, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against me.

By signing below, you agree to share the above information. You may revoke/cancel this consent at any time by sending written notice to Jefferson Health Plans or submitting a revocation form.

Member name: _____

Signature: _____

Date: _____

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PERSONAL OR AUTHORIZED REPRESENTATIVE SIGNATURE

Personal/Authorized Representative (If Any): A copy of a Power of Attorney or other legal document that proves you can act for the member must be on file at Jefferson Health Plans or submitted with this form.

Relationship to Member: _____

Signature of Personal Representative: _____

Telephone Number: _____

If I am unable to sign my name below, verbally acknowledging that I have read and agree to the terms of this Authorization.

Name of Mental Health Information Witness #1: _____

Signature: _____ Date: _____

Name of Mental Health Information Witness #2: _____

Signature: _____ Date: _____

Name of Drug/Alcohol Treatment Information Witness: _____

A copy of this form was offered to member: ☐ Accepted ☐ Declined

Jefferson Health Plans

Discrimination is Against the Law

Jefferson Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Jefferson Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Jefferson Health Plans provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Jefferson Health Plans provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Member Relations at **1-833-422-4690 (TTY 1-877-454-8477).**

If you believe that Jefferson Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

Jefferson Health Plans
Attn: Complaints, Grievances & Appeals Unit
1101 Market Street, Suite 3000
Philadelphia, PA 19107
Phone: 1-833-422-4690 (TTY 1-877-454-8477)
Fax: 1-215-991-4105

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or email at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW.,
Room 509F, HHH Building,
Washington, DC 20201,
1-800-368-1019, 800-537-7697 (TDD).
OCRMail@hhs.gov

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Jefferson Health Plans is underwritten by Health Partners Plans, Inc., and Partners Insurance Company, Inc., which hold Pennsylvania Licenses as a Health Maintenance Organization, Insurer, and Preferred Provider Organization, Insurer, respectively, and Qualified Health Plan Issuers in the Pennsylvania Health Insurance Marketplace.

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Notices of Availability

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-833-422-4690 (TTY 1-877-454-8477) or speak to your provider.

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-833-422-4690 (TTY 1-877-454-8477) o hable con su proveedor.

Chinese; Mandarin
注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-833-422-4690（文本电话：1-877-454-8477）或咨询您的服务提供商。

Nepali
सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि गि: शुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि नि: शुल्क उपलब्ध छन्। 1-833-422-4690 (TTY 1-877-454-8477) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Russian
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-833-422-4690 (TTY: 1-877-454-8477) или обратитесь к своему поставщику услуг.

Arabic
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مبسطة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-833-422-4690 (1-877-454-8477) أو تحدث إلى مقدم الخدمة.

Haitian Creole
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-833-422-4690 (TTY: 1-877-454-8477) oswa pale avèk founisè w la.

Vietnamese
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-833-422-4690 (Người khuyết tật: 1-877-454-8477) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Ukrainian
УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-833-422-4690 (TTY: 1-877-454-8477) або зверніться до свого постачальника.

Chinese; Cantonese
注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-833-422-4690 (TTY: 1-877-454-8477) 或與您的提供者討論。

Portuguese
ATENÇÃO: Se você fala português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-833-422-4690 (TTY: 1-877-454-8477) ou fale com seu provedor.

Bengali
মনোযোগ দিন: দি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-833-422-4690 (TTY: 1-877-454-8477) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

French
ATTENTION: Si vous parlez Français, des services d’assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-833-422-4690 (TTY: 1-877-454-8477) ou parlez à votre fournisseur.

Cambodian
សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ *ភាសាខ្មែរ* សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-833-422-4690 (TTY: 1-877-454-8477) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Korean
주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-833-422-4690 (TTY: 1-877-454-8477)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Gujarati
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-833-422-4690 (TTY: 1-877-454-8477) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.