



# Instructions

## Consent to Release Protected Health Information (PHI) Form

**Consent to Release Protected Health Information (PHI) Form** – Use this form to allow us to share your health information.

Please complete the Consent to Release Protected Health Information Form to give us your OK to share your health information.

If you have any questions about anything on this form, please call 1-800-424-4046.

### Part 1. Who is the member?

This is information about you. Please write your name, address, date of birth and Medicaid ID number of the member who is giving Magellan of Virginia the OK to share his or her health information.

In the area called “Check One,” please check the box to tell us who is filling out the form.

- If it is you, the member, then check the first box.
- If it is someone the law says can act for you, then check the second box. Next, tell us the first and last name of that person.
- If you checked the box as Guardian or Other, please include the documentation that shows that you have the legal authority to request this information on the member’s behalf.

### Part 2. Who can give out the PHI?

This is information about Magellan Healthcare of Virginia, Inc. This section says we can share your health information once you say it is OK.

### Part 3. Who can the PHI be given to?

List who we can share your health information with. Please write the person’s first and last name or the name of the place that can have your PHI. We also need the phone number and address if you know it. Only list one person or one provider/facility in this section.

### Part 4. What PHI can we share?

We will only share the health information that you say is OK to share. This can be health information about your mental health, alcohol or drug treatment. It does not cover psychotherapy notes that are not in your medical file.

### **Part 5. Why are you giving out this PHI?**

Please tell us the reason you want us to share your health information.

### **Part 6. When does my OK end?**

You can tell us when we can no longer share your health information.

- Check the first box if you want the sharing to end after one (1) year or
- Check the second box if you want the sharing to end sooner than one (1) year. Then fill in when it should end.

### **Part 7. Your Rights and Important Facts**

Please read this part of the form slowly. It talks about your rights and other important facts.

### **Part 8. Signature of Member**

This is where you sign your name and put the date you signed the form. We cannot share your health information if you do not sign the form.

### **Part 9. Signature of authorized representative (if any)**

This section must be filled in if it is not the member filling in the form.

**Please Note:** No personal comments of any kind from the member or person completing the AUD Form are allowed in any section of this form.

Once you complete the form you can mail the form to:

**Magellan Healthcare of Virginia  
P. O. Box 5879  
Glen Allen, VA 23058**