Behavioral Health Services

Consent Form for the Release of Medical Information

If you receive behavioral health services such as mental health or substance abuse care, you need to give your behavioral health provider consent before he or she can communicate your behavioral health diagnosis and treatment information to your primary care physician (PCP), specialist, or other behavioral health provider.

MassHealth requires BMC HealthNet Plan to help you, your PCP, and your behavioral health provider coordinate all aspects of your behavioral health and medical care. The people taking care of you need information from each other to fully understand your healthcare needs. By allowing your PCP, specialist, behavioral health provider, and BMC HealthNet Plan to communicate with each other you will receive better health care services.

Therefore, we ask that you give your consent to allow your behavioral health provider(s) and BMC HealthNet Plan to disclose your behavioral health diagnosis and treatment information to your PCP, specialist, and other behavioral health provider(s) so that we can better manage your health care needs.

Please carefully review the following statements. If you agree with the statements please sign in the space indicated for your signature:

1. I hereby authorize my behavioral health provider(s) who may care for me during my enrollment as a member of BMC HealthNet Plan to disclose my behavioral health diagnosis and treatment information, including mental health, substance abuse and prescription drug information, to my PCP, specialist, other behavioral health provider, or BMC HealthNet Plan for purposes of care coordination and treatment.

2. I hereby authorize BMC HealthNet Plan to disclose my behavioral health diagnosis and treatment information, including mental health, substance abuse and prescription drug information to my PCP, specialist, and other behavioral health provider for purposes of care coordination and treatment.

3. This consent does not authorize the release of certain other legally protected information. Specifically, if you would like any information or records related to the following types of information released, you must indicate this by initialing the box next to the specific item you would like released. The following categories of information WILL NOT be released unless you specifically initial next to the specific category:

AIDS/ARC and/or HIV testing and results
Genetic testing and results
Abortion
Sexual Assault
Domestic violence
Sexually Transmitted Diseases
Mammography Reports

4. I understand that I may revoke this consent at any time. I understand that revoking my consent will not be effective in any situation where BMC HealthNet Plan, my PCP, specialist, or behavioral health provider(s) have already acted on my consent in good faith. I understand that I may revoke my consent by writing to BMC HealthNet Plan and my behavioral health provider(s).

5. I understand that I am not required to give my consent or sign this consent form, and that my refusing to sign the consent form will not affect my eligibility from treatment, benefits, or coverage.

6. I understand that this consent form will expire upon termination of my status as a member of BMC HealthNet Plan.

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Signature of Member or Representative	Date	Member's Name
Personal Representative's Name	Date	Relationship to Member

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