

Intensive Clinical Management Release of Medical and Pharmacy Information Form

When you complete this BMC HealthNet Plan form, you are authorizing the disclosure and/or use of individually identifiable health information, as set forth below, consistent with state and federal laws concerning the privacy of such information. If you do not provide all the information requested, this authorization may not be valid.

Member Name: _____
 Member ID or Social Security number: _____
 Member telephone: _____
 Member address: _____

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize BMC HealthNet Plan to release my medical and pharmacy information to:
(Persons or organizations to whom information may be disclosed)

- | | |
|--------------------------|-------------------------|
| 1. FST/CSP agency: _____ | 5. Outpatient: _____ |
| 2. PCC: _____ | 6. Crisis team: _____ |
| 3. State agency: _____ | 7. Hospital/CBAT: _____ |
| 4. State agency: _____ | 8. Other: _____ |

PURPOSE OF REQUESTED USE OR DISCLOSURE

I hereby authorize BMC HealthNet Plan to release my medical information for the following purpose(s):

- | | |
|--|---|
| <input type="checkbox"/> Claims information
(from _____ to _____)
<input type="checkbox"/> All claims information
<input type="checkbox"/> Clinical information
(from _____ to _____)
<input type="checkbox"/> All clinical information
<input type="checkbox"/> Pharmacy Data | <input type="checkbox"/> Appeal and review information
(from _____ to _____)
<input type="checkbox"/> All appeal and review information
<input type="checkbox"/> Designated record set
(from _____ to _____)
<input type="checkbox"/> The entire designated record set |
|--|---|

(continued)

INFORMATION TO WHICH THE AUTHORIZATION APPLIES

I hereby authorize BMC HealthNet Plan to release the following medical information:

Please specify exactly the information you wish to have released and include any date limitations, if applicable (e.g., all claims information from June 1999 to February 2002).

SEPARATE AUTHORIZATION FOR RELEASE OF STATUTORILY PROTECTED INFORMATION

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:

Behavioral health information
Diagnosis and/or treatment of alcohol or drug abuse
AIDS/ARC and/or HIV testing and results
Genetic testing and results
Abortion
Sexual Assault
Domestic violence
Sexually Transmitted Diseases
Mammography Reports

TERMINATION OF AUTHORIZATION

This authorization expires on (date or event): _____

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this authorization. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization. I may take back (“revoke”) this authorization at any time. To revoke this authorization, I must send a letter, which has been signed by me or on my behalf to: BMC HealthNet Plan, Two Copley Place, Suite 600, Boston, MA 02216. My revocation will be effective upon receipt by BMC HealthNet Plan but will not affect disclosures already made in reliance on prior consent.

Except as described above with respect to drug and alcohol abuse records, information disclosed as a result of this authorization could be redisclosed by the recipient and may no longer be protected by federal confidentiality laws.

I may inspect or obtain a copy of the health information to be used or disclosed as permitted under federal or state law.

SIGNATURE

Date: _____

Time: _____ am / pm

Signature: _____

Member or Authorized Representative

If signed by someone other than the individual or member, state your legal relationship to the individual or member:
