

# Authorization to Disclose Information

Protecting your confidentiality is important to MVP Health Care, Inc. and its subsidiaries (collectively, “MVP”). If you would like MVP to share your health information with another party, you must first give your permission to do so.

By completing and signing this form, you give that permission. MVP may then share your health information with the people you have authorized. Please read this form carefully.

## Instructions for Completing this Form

There are six sections on this form to complete.

### **Section 1: Fill in your name, MVP member identification number, address, and date of birth identifying you as the MVP member.**

This section may also be used if you are giving MVP permission to share health information of a minor for whom you are the parent or legal guardian.

### **Section 2: Fill in the name(s), address(es), and phone number(s) of the person(s) with whom you are authorizing MVP to share your health information.**

Be sure to write the contact’s full name and address. MVP will only share information if the contact correctly verifies the name, address, and phone number you have written.

### **Section 3: Reason for the disclosure.**

This section tells MVP the reason for the disclosure.

### **Section 4: Select the health information you are authorizing MVP to share.**

There are three options:

- The **first** option gives MVP permission to share all of your health information, except for information involving HIV/AIDS, mental health and substance use, family planning and pregnancy, or sexually transmitted diseases. You must specifically authorize MVP to share this information with another party.
- The **second** option gives MVP permission to share only the information you specify, such as eligibility information only, information specific to a particular service, or claims information for a specific provider.

- The **third** option gives MVP permission to share information about HIV/AIDS, mental health and substance use, family planning and pregnancy, or sexually transmitted diseases, and is explained more fully below.

### **Information for Parents of Minors with Sensitive Diagnoses**

MVP has a policy in place to protect the privacy of minors with sensitive diagnoses. MVP has developed this position based upon legal requirements together with MVP’s commitment to safeguarding the privacy of its members who receive care for sensitive needs. If a minor 12–18 years old receives services or treatment related to mental health, chemical dependency or substance use, venereal disease, HIV/AIDS, family planning, prenatal care, or abortion-related services, MVP must have an Authorization to Disclose Information form on file from the minor to disclose most information to a parent or guardian.

**MVP will not share this information if you have not authorized MVP to do so by initialing the specific items.** Please read the special notice from the New York State Department of Health on page 2 of these instructions.

### **Section 5: Read and make sure you understand your rights under this authorization.**

You may use this section to specify an expiration date on this form, otherwise it will remain in effect indefinitely or until you request it to be revoked.

**For members covered on plans written in the State of Vermont,** this form shall be valid until the expiration date you specify, which in no event shall be more than 24 months.

### **Section 6: Sign and date the form and print your name underneath your signature.**

If you are using this form to give MVP permission to share health information of a minor for whom you are the parent or legal guardian, make sure to write in your relationship to that member.

If you are authorizing a person to act on your behalf, that person must also sign and date the form.

By signing this form electronically, you acknowledge that your electronic signature has the same legal consequences as your written signature.

When completed, please email, mail, or fax the completed *Authorization to Disclose Information* form to the email address, mailing address, or fax number on the top of the form.

### **Your Rights Related to the Authorization to Disclose Information**

1. You may authorize someone to appeal an issue on your behalf (with the exception of Medicare members, additional information is required). By doing so you are exercising your right to appeal and will not be permitted to appeal the same issue yourself.
2. MVP shall not condition treatment, payment, enrollment, or eligibility for benefits under its insured plans on receipt of this authorization.
3. Information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
4. If information is disclosed from alcohol and drug use records protected by Federal confidentiality rules (42 CFR Part 2), these Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

### **Your Rights Relating to the Release of Confidential HIV\* Related Information**

Confidential HIV related information is any information indicating that a person had an HIV

related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, confidential HIV related information can only be given to people you allow to have it by signing a written release, or to people who need to know your HIV status in order to provide medical care and services, including: medical care providers; persons involved with foster care or adoption; parents and guardians who consent to care of minors; jail, prison, probation and parole employees; emergency response workers and other workers in hospitals, other regulated settings or medical offices, who are exposed to blood/ body fluids in the course of their employment; and organizations that review the services you receive. State law also allows your HIV information to be released under limited circumstances: by special court order; to public health officials as required by law; and to insurers as necessary to pay for care and treatment. Under State law, anyone who illegally discloses HIV related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of such information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at **1-800-962-5065**.

By signing and initialing where indicated on the form, HIV related information can be given to the people listed on the form, and for the reason(s) you may list on the form. You do not have to sign the form, and you can change your mind at any time by indicating your change in writing.

The law protects you from HIV-related discrimination in housing, employment, health care, and other services. For more information, call the New York State Division of Human Rights Office at **1-888-392-3644** or the New York City Commission on Human Rights at **212-306-7450**. These agencies are responsible for protecting your rights.

\*Human Immunodeficiency Virus that causes AIDS.



# Authorization to Disclose Information

By completing this form, you allow MVP Health Care® to disclose health information to those identified below.

Return this completed form by email, mail, or fax

Email: **members@mvphealthcare.com**

Mail:

**MVP Health Care  
PO Box 2207  
Schenectady NY 12301-2207**

Fax: **1-800-765-3808**

## If This Form is Needed for An Appeal

Return this completed form by email, mail, or fax.

Email: **memappeals@mvphealthcare.com**

Mail:

**Attn: Appeals  
MVP Health Care  
PO Box 2207  
Schenectady NY 12301-2207**

Fax: **518-386-7600**

### Section 1: Information About the Member Whose Information is to be Released

*(please print)*

Member Name		Date of Birth	MVP Member ID No.	
Street Address		City	State	Zip Code

### Section 2: Information About the Person(s) with Whom Your Health Information is to be Shared

Name		Phone No.		
Street Address		City	State	Zip Code
Name		Phone No.		
Street Address		City	State	Zip Code

### Section 3: Reason for the Disclosure

Request of Individual     Other *(explain)*: \_\_\_\_\_

### Section 4: Health Information to be Released *(check all that apply)*

All health information *(except the health information that requires your initials below)*

Other *(specify the health information you are authorizing MVP to disclose)*: \_\_\_\_\_

<i>Member Name</i>	<i>MVP Member ID No.</i>
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*(Section 4 continued)*

**If you initial any items below, MVP can discuss the health information with the appointed person(s).**

- (Initials)* HIV/AIDS related information and/or records *(see page 2 of instructions)*
- (Initials)* Mental health information and/or records
- (Initials)* Drug/alcohol diagnosis and treatment information
- (Initials)* Pregnancy, family planning, abortion information
- (Initials)* Sexually transmitted disease information

**Information for Parents of Minors with Sensitive Diagnoses:** MVP has a policy in place to protect the privacy of minors with sensitive diagnoses. MVP has developed this position based upon legal requirements together with MVP’s commitment to safeguarding the privacy of its members who receive care for sensitive needs. If a minor 12–18 years old receives services or treatment related to mental health, chemical dependency or substance use, venereal disease, HIV/AIDS, family planning, prenatal care, or abortion-related services, MVP must have an Authorization to Disclose Information form on file from the minor to disclose most information to a parent or guardian.

**Section 5: Read and Understand Your Rights** *(see page 2 of instructions)*

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This authorization shall be in force and effect until such time as MVP Health Care no longer maintains the health information, or until revoked by the undersigned in the manner described below or until *(insert applicable date or event)* \_\_\_\_\_.

I understand that I have the right to revoke this authorization, at any time by sending written notification to the address indicated below. The revocation should clearly state your intent to revoke this authorization and the date such revocation is to take effect.

**For members covered on plans written in the State of Vermont,** this form shall be valid until the expiration date you specify, which in no event shall be more than 24 months.

**Section 6: Sign and Date this Form**

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By signing this form electronically, you acknowledge that your electronic signature has the same legal consequences as your written signature.

<i>Member Signature</i>	<i>Name (print)</i>	<i>Signature Date</i>

<i>Authorized Representative Signature</i>	<i>Name (print)</i>	<i>Signature Date</i>

<i>Authorized Representative Signature</i>	<i>Name (print)</i>	<i>Signature Date</i>