Authorization to Disclose Information

MVP HEALTH CARE

Instructions for Completing this Form

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.

There are five 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 2A **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 and address you have written.

SECTION 2B **Reason for the disclosure.**

This section tells MVP the reason for the disclosure.

SECTION 3 **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, psychiatric and substance abuse, 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, psychiatric and substance abuse, family planning and pregnancy, or sexually transmitted diseases, and is explained more fully below. ***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.

SECTION 4 **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.

SECTION 5 **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.

When completed, please mail or fax the completed *Authorization to Disclose Information* form to the address or fax number on the bottom 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 abuse 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 page 3 of this 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

If you complete this form you allow MVP to disclose health information to those identified below.

SECTION 1 Information About the Member Whose Information is to be Released

MVP Member ID Number | | | | | | | | | | | |

Member Name ____________________ Date of Birth ___ / ___ / ___

Street Address ____________________

City ____________ State ______ Zip Code ______

SECTION 2A Information About the Person(s) With Whom your Health Information is to be Shared

I authorize MVP to disclose health information to *(please print)*:

	Name	*Address*	*Phone*
1)			
2)			

SECTION 2B Reason for the Disclosure

☐ Request of individual ☐ Other: ____________________

SECTION 3 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)*:

____

If you initial these items 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

SECTION 4 Read and Understand Your Rights *(See pages 2 of instructions)*

This authorization shall be in force and effect until such time as MVP 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.

SECTION 5 Sign and Date this Form

Signature ____________________ Print Name ____________________

Date (MM/DD/YYYY) ___ / ___ / **20** ___ Relationship to Member ____________________

Return this completed form to: MVP HEALTH CARE
PO BOX 2207
SCHENECTADY NY 12301-2207

Or fax it to **1-800-765-3808**