MVP HEALTH CARE
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 filling out 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 (5) Sections on this form.

SECTION 1- Fill in your Name, MVP Member ID#, Address, and Date of Birth identifying you as the member.
This section may also be used if you are giving MVP permission to share health information on 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) you are authorizing MVP to share your health information with.
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 Disclosure
This section tells MVP the reason for the disclosure.

SECTION 3- Select the health information you are authorizing MVP to share.
There are **3** 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 us to do so by initialing the specific items.** Please read the special notice from the NYS 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.
You can use this form if you are giving MVP permission to share health information on a minor for whom you are the parent or legal guardian. If so, 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 of AIDS Discrimination Issues at **1 (800) 523-2437** or **(212) 480-2493** or the New York City Commission of Human Rights at **(212) 306-5070**. These agencies are responsible for protecting your rights.

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* Human Immunodeficiency Virus that causes AIDS.

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By completing this form you are allowing MVP to disclose health care information to the individuals you identify.

SECTION 1- INDICATE THE MEMBER WHOSE INFORMATION IS TO BE RELEASED:

Name_____ Member ID#_____ DOB____/____/____

Street Address_____

City_____State_____Zip Code_____

SECTION 2A- I AUTHORIZE MVP TO DISCLOSE HEALTH INFORMATION TO:

(Print the Name(s), Address(es) and Telephone Number(s) of the person(s) you would like to appoint)

_____

_____

_____

SECTION 2B- REASON FOR DISCLOSURE:

☐ Request of Individual ☐ Other:_____

SECTION 3- INDICATE THE HEALTH INFORMATION TO BE RELEASED:

____ All Health Information **(except the health information listed below)**

____ Other *(specify the information you are authorizing MVP to disclose)* _____

The following items must be initialed in order for MVP to discuss these types of health information with the person(s) you have appointed:

____ HIV/AIDS related information and/or records (**SEE PAGE 2**)
____ Mental health information and/or records
____ Drug/alcohol diagnosis and treatment information
____ Pregnancy, family planning, abortion information
____ Sexually transmitted disease information

SECTION 4- READ AND UNDERSTAND YOUR RIGHTS (SEE PAGE 2):

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 Date (DD/MM/YY)

_____ _____
Print Name Relationship to Member

Rochester & Buffalo Regions, send this form to:
MVP Member Services Department / 220 Alexander Street / Rochester, New York 14607
or fax it toll free to: 1-800-396-1869

All Other Regions, send this form to:
MVP Member Services Department / PO Box 2207 / Schenectady, New York 12301-2207
or fax it toll-free to 1-800-765-3808

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