

MVP HEALTH CARE THIRD PARTY AUTHORIZATION FORM



Please complete this form if you want another person to deal with MVP on your behalf. MVP takes pride in protecting your health information and will not discuss it with another person, including your spouse, insurance broker or human resources representative, unless you authorize MVP to do so by completing this form.

If you wish to appoint your employer or insurance broker to act on your behalf with MVP, please be sure to list the names of the individuals at your employer or insurance broker who you authorize to act on your behalf. These listed individuals will act for you.

I, the undersigned, hereby authorize MVP Health Plan, Inc., MVP Select Care, Inc., MVP Health Insurance Company or MVP Health Services Corp. (collectively "MVP") to disclose the health information identified below to the following person(s):

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

Please indicate the following information regarding the person whose health information is to be released.

Name _____ Member ID# _____ DOB ____/____/____ (MM/DD/YY)

Please indicate the health information to be released:

____ All of Your Health Information (Check this box if you want another person to deal with MVP on your behalf for all of your questions or issues.)

____ Other _____

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

____ HIV/AIDS related information and/or records (as referenced on Page 2 of this form)

____ Mental health information and/or records

____ Drug/alcohol diagnosis and treatment information

Please indicate the purpose of the disclosure (optional):

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 by certified mail to: MVP, P.O. Box 2207, 625 State Street, Schenectady, New York 12305, ATTN: MVP Member Service Department. The revocation should clearly state your intent to revoke this authorization and the date such revocation is to take effect.

You may authorize someone to appeal an issue on your behalf. By doing so you are exercising your right to appeal and will not be permitted to appeal the same issue yourself.

MVP shall not condition treatment, payment, enrollment or eligibility for benefits under its insured plans on receipt of this authorization.

I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

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.

Signature _____ Date ____/____/____ (MM/DD/YY)

Print Name _____ Relationship to Member _____

Send this form to MVP Member Services Dept., P.O. Box 2207 Schenectady, NY 12301 or fax it toll-free at 1-800-765-3808



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 1 of this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed 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.

* Human Immunodeficiency Virus that causes AIDS.