



# MFP Authorization For Use Or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Georgia and Federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this Authorization.**

## USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Member Name: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

Health Plan Name: \_\_\_\_\_

Persons/Organizations authorized to *receive, use or disclose* the information <sup>i</sup> are:

- Options Counselors/ MFP Transition Coordinators/ Case Expeditors
- Waiver assessment/case management staff
- Representative (Legal, etc.)
- MFP service providers (Peers, Ombudsman, etc.)

Purpose of requested use or disclosure: <sup>ii</sup> for screening and assessment and participation in the MFP Project.

This Authorization applies to the following information (select **only one** of the following):<sup>iii</sup>

- All health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] **Except:** \_\_\_\_\_

- Only** the following records or types of health information (including any dates). This may consist of psychotherapy notes, if specifically authorized:

\_\_\_\_\_

\_\_\_\_\_

## EXPIRATION

All information I hereby authorize to be obtained from this nursing facility/institution will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for: (PLEASE CHECK ONE)

- ninety (90) days unless I specify an earlier date here: \_\_\_\_\_
- one (1) year
- the period necessary to complete all transactions related to my participation in the Money Follows the Person Project on matters related to services provided to me through the Money Follows the Person Project.

*I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.*



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## NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: \_\_\_\_\_

\_\_\_\_\_.

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.<sup>iv</sup>

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.<sup>v</sup>

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).

\_\_\_\_\_  
Signature of Member or Authorized Representative Date

\_\_\_\_\_  
If Signed by Representative, State Relationship or Basis of Authority

<sup>i</sup> If the Authorization is being requested by the entity holding the information, this entity is the Requestor.

<sup>ii</sup> The statement "at the request of the individual" is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

<sup>iii</sup> This form may not be used to release both psychotherapy notes and other types of health information (see 45 CFR § 164.508(b)(3)(ii)). **If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.**

<sup>iv</sup> Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 CFR § 164.508(d)(1), (e)(2)).

<sup>v</sup> If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. **Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.**