



# MFP Release of Health Information (MFP RHI)

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 release, use or disclosure of my health information as follows:

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

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

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

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

- MFP Field Personnel \*
- Waiver assessment/case management staff \*
- My Representative (Legal, etc.) \*
- MFP service providers (Peers, Ombudsman, etc.) \*

*\* Personnel located in Georgia and in the state to which you are transitioning.*

Purpose of requested use or disclosure: <sup>ii</sup> for screening and assessment and participation in MFP. 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 inpatient facility 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 transactions related to my participation in Money Follows the Person on matters related to services provided to me through Money Follows the Person.

*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
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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.**