COMMONWEALTH CARE ALLIANCE/CCA PRIMARY CARE

ROI Form: Authorization for Use or Disclosure of Health Information - Instructions

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Use this form to:

- Disclose Member/Patient health information from Commonwealth Care Alliance/CCA Primary Care (CCA) to a person or organization, or

- Obtain from a person or organization Member/Patient health information to share with CCA.

This form allows the Member/Patient health information to be shared via verbal conversation or records access.

Examples of how the Member/Patient and the Member/Patient Representative can use the form: .
• **Member wants to authorize release of health information to their attorney**: When the Member/Patient wants their attorney to have access to their health information via records and/or oral communication, the Member/Patient should simply write the attorney's name and contact information in section 2 and complete the rest of the form. No proof of attorney-client relationship is required. The Member/Patient has the right to indicate whomever they would like to have their information released to. This would be the same process whether the recipient is an attorney, patient advocate, family member, etc.
• **Personal Representative wants to authorize release of health information**: When the Member/Patient's Personal Representative is an attorney, and the attorney, standing in the shoes of the Member/Patient, fills out this form to authorize release of records and/or oral communication, in that scenario, the attorney **would** need to provide evidence that they in fact represent the Member/Patient and have the authority to act as the Member/Patient's Personal Representative and authorize release of the Member/Patient's information. Same for a guardian (proof of guardianship decree), health care agent (proof of invoked health care proxy), etc.

Instructions to complete the form:

1. **Member/Patient information**
   Print the Member/Patient's name, address, date of birth, phone number, CCA identification number and email.

2. **Permission to release/disclose Member/Patient health information**
   Check the box to show whether you are requesting to disclose or obtain the Member/Patient's health information and the name of the Person/Organization, phone number, email, street address, city, state and zip code. Check the box to describe whether you want the full or partial record released, the dates or if indefinite. You have the option of indicating the purpose. Then, indicate whether the use/disclosure should be oral or written and/or electronic or paper records to be faxed, emailed, delivered or picked up.

3. **Sensitive Information: You must initial each box below in order for us to release this sensitive information**
   If you want certain sensitive records released you must initial each box, otherwise it will not be released.

4. **Expiration and Cancellation**
   Indicate the date you want this form to expire or the event upon which it will expire.

5. **Sign Below: The signature below is my own and I am legally authorized to sign this document**
   If you are the Member/Patient, sign and date in the spaces. If you are signing this form as Personal Representative of the Member/Patient, print your name in the space, include your phone number and email. Check the box that describes your legal authority to request use or disclosure of Member/Patient health information. Provide supporting documentation. Examples of acceptable documents include:

   Attorney: *Attach evidence that you are the Member/Patient's attorney*

   Guardian/Conservator: *Attach probate court order/decree.*

   Health Care Agent: *Attach copy of invoked Health Care Proxy and evidence of being invoked*

   HIPAA Agent/Representative: *Attach copy of HIPAA Release/Authorization*

   Representative of Estate/Executor: *Attach copy of appointment letters from probate court*

   Power of Attorney: *Attach POA that includes your authority to use/disclose health information*

   Other Advocate: *Attach document that explains your legal authority and relationship*

Please mail, fax, or email as indicated below. For questions call Member Services at: 866-610-2273

IF YOU WANT TO INITIATE ANY ACTION ON BEHALF OF THE MEMBER (FOR EXAMPLE: make appointments, cancel appointments, initiate organization determinations, enroll or disenroll a member)

If you want to	**Then use this form**	**Personal Representative's scope of authority**
Appoint a representative to act on behalf of the member/patient to **initiate an appeal, claim, grievance or organization determination, receive any information about that appeal, claim, grievance or organization determination**, including the decision.	Appointment of Representative Form CMS-1696 (AOR form) to appoint a representative.	The representative must **file a copy of the AOR form along with the appeal request**. The appointment is valid for one year from the date on the form. The action must be filed within that 1-year time and the representation is valid for the duration of the action.
Designate an authorized representative to act on behalf of the applicant to **help you get health care coverage through programs offered by MassHealth**. This can also be a person who is authorized by law	Authorized Representative Designation Form ARD from MassHealth to appoint an authorized	The authorized representative may: **fill out MassHealth application or renewal forms; fill out other MassHealth or Health Connector eligibility or enrollment forms**; give proof of

to act on your behalf. The selected authorized representative must be a person, not an organization.	representative.	information on those forms; get copies of MassHealth and Health Connector eligibility and enrollment notices; and act on your behalf in all other matters with MassHealth and the Health Connector.
Have someone **make health care decisions** on your behalf	An invoked **Health Care Proxy** form.	Depending on the wording of the invoked Health Care Proxy form, or a court order, a **Health Care Agent**, shall have the right to receive all medical information, including all confidential medical information that the member/patient would be entitled to receive and after consulting with the member/patient's health care providers **can make any and all health care decisions** on the member/patient would have been able to make, including decisions about life-sustaining treatment. The decisions must be based on the member/patient's wishes if known, and if not known, then in the member/patient's best interests.
The Member/Patient has died and medical or coverage information is desired/needed.	**Letters of Authority** from a Probate Court.	The **Personal Representative of Estate or Executor**, in accordance with the Letters of Authority may have access to any information about the Member/Patient.
Depending on the scope of the Power of Attorney document, might be able to make health care decisions, get access to information.	**Power of Attorney** – may also be known as Durable Power of Attorney or Health Care Power of	The **Holder of the Power of Attorney also known as the "Attorney-in-Fact"** can make or do anything that is outlined in the Power of Attorney document. This might or might not include making health

	Attorney	care decisions.