INSTRUCTIONS TO AUTHORIZE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (ROI) form is used to either:

- Disclose member health information to a person or organization, or
- Obtain member health information from a person or organization, such as a healthcare provider or hospital, to share with Commonwealth Care Alliance (CCA).

The ROI form can be revoked at any time by written or emailed request to CCA's Health Information Management Department.

Examples of how to use the ROI form:

See detailed instructions for completing the ROI form on page 4.

1. **Member wants to authorize release of CCA health information to their attorney:**
    a. The member must complete the ROI form, including the attorney's name and contact information in section 2.
    b. No proof of attorney-client relationship is required.
    c. This would be the same process for all recipients. The member has the right to indicate anyone as a recipient of their health information, including an attorney, advocate, family member, etc.
2. **Member's Personal Representative is an attorney and wants to authorize the release of CCA the health information:**
    a. As the member's Personal Representative, the attorney is authorized to complete the ROI form to release the member's health information.
    b. The attorney must check the Personal Representative boxes on the ROI form in section 5.
    c. The attorney is required to provide evidence that they represent the member, have the authority to act as the member's Personal Representative, and authorize release of the health information.
    d. This would be the same process for any type of Personal Representative.

For questions about the ROI form:

Call 866-610-2273. TTY users call 711. We are open 8 am to 8 pm, 7 days a week.

For information about connecting your health information from CCA to an application (app) of your choice, visit: https://www.commonwealthcarealliance.org/interoperability/

HOW TO INITIATE OTHER ACTIONS ON BEHALF OF A CCA MEMBER

If you want to…	Use this form	Scope of authority
Appoint a Representative to act on behalf of the member to initiate an appeal, claim, grievance, or organization determination, receive any information about that appeal, claim, grievance, or organization determination, including the decision	CMS Appointment of Representative (AOR) form (CMS-1696)	The appointment is valid for one year from the date on the form. The action must be filed within that one-year timeframe and the representation is valid for the duration of the action. The representative must file a copy of the AOR form along with the appeal request.
Designate an Authorized Representative to act on behalf of the member to help get healthcare coverage through programs offered by your state Medicaid program. This can also be a person who is authorized by law to act on the member's behalf. The selected Authorized Representative must be a person, not an organization	MassHealth Authorized Representative Designation (ARD) form	The Authorized Representative may: fill out the state Medicaid application or renewal forms; fill out other Medicaid eligibility or enrollment forms from your state; give proof of information on those forms; get copies of your state's Medicaid eligibility and enrollment notices; and act on the member's behalf in all other matters with your state Medicaid program.
Appoint a Health Care Agent to make healthcare decisions on the member's behalf		Depending on the wording of the form, or a court order, the health care

		agent or attorney in fact has the right to receive all medical information that the Member would be entitled to receive. After consulting with the Member's healthcare providers, the health care agent or attorney in fact can make any and all healthcare decisions the Member would have been able to make, including decisions about life-sustaining treatment. The decisions must be based on the Member's wishes if known; if not known, then in the Member's best interests.
Access medical or coverage information when the Member has died	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.
Appoint a Power of Attorney to make health care decisions, get access to information, and other actions depending on scope of the Power of Attorney document	Power of Attorney – may also be known as Durable Power of Attorney or Health Care Power of Attorney	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 may or may not include making healthcare decisions.

INSTRUCTIONS FOR HOW TO COMPLETE THE ROI FORM:

Section 1: Member Information

- Print the member's name, CCA member identification (ID) number, date of birth, address, phone number and email address, if applicable.

Section 2: **Permission to Obtain/Disclose Member Protected Health Information**

- Complete the appropriate section to indicate if you are requesting to obtain health information OR disclose the health information. If the "Obtain from" box is checked, the records will be uploaded and included into your CCA chart once received.
- Print the name, address, phone number, and email address of the Person/Organization for which you are either disclosing or obtaining the health information.
- Check the box to request a full or partial record. If partial, describe the health information or type of records needed. For example, if you want a copy of the last year of MDS or Care Plans.
- Indicate the time frame for which the health records should cover.
- Indicate the purpose for releasing the information.
- Check the box to indicate how the health information should be delivered: written and/or electronic/paper records can be faxed, emailed or delivered by U.S. Mail, FedEx or some other means.

Section 3: Sensitive Information

- If you want certain sensitive records released, you must initial the box, otherwise it will not be released.

Section 4: Expiration and Revocation

Indicate the date you want this form to expire or the event upon which it will expire. (For example: upon discharge from the hospital.) If the form is completed to disclose CCA records, it will expire one (1) year from the date you sign the form. If the form is completed for CCA to obtain records from another provider, it will be valid for the member's enrollment term with CCA unless otherwise revoked.

Section 5: Signature

If you are the member, sign and date in the spaces provided. If you are signing this form as Personal Representative, print your name in the space, phone number, and email. Check the box that describes your legal authority to release health information on behalf of the member and provide supporting documentation.

Examples of acceptable documents include:

- Attorney: Evidence that you are the Member's attorney
- Guardian/Conservator: Probate court order/decree
- Health Care Agent: Copy of invoked health care proxy and proof of being invoked.
- HIPAA Agent/Representative: Attach copy of HIPAA release/authorization form.
- Representative of Estate/Executor: Copy of appointment letters from probate court
- Power of Attorney (POA): POA that includes authority to use/disclose health information.
- Other Advocate: Document that explains your legal authority and relationship.

Submit the completed ROI form to:	Commonwealth Care Alliance, Inc., Health Information Management 2 Avenue De Lafayette, 5th Floor Boston, MA 02111 **Fax:** 413-733-1924 **Email:** HIM@commonwealthcare.org

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ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Los miembros de Massachusetts deben llamar al 866-610-2273 (TTY 711).

You can get this document for free in other formats, such as large print, braille, or audio. Call 866-610-2273. TTY users call 711. We are open 8 am to 8 pm, 7 days a week. The call is free.

Notice of Nondiscrimination

Commonwealth Care Alliance, Inc.® complies with applicable Federal civil rights laws and does not discriminate on the basis of, or exclude people or treat them differently because of, medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence. Commonwealth Care Alliance, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services.

If you believe that Commonwealth Care Alliance, Inc. has failed to provide these services or discriminated in another way based on medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence, you can file a grievance with:

Commonwealth Care Alliance, Inc.
Civil Rights Coordinator
30 Winter Street, 11th Floor
Boston, MA 02108
Phone: 617-960-0474, ext. 3932 (TTY 711) Fax: 857-453-4517
Email: civilrightscoordinator@commonwealthcare.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.