

# MVP HEALTH CARE REQUEST FOR THE RELEASE OF HEALTH INFORMATION

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

Name \_\_\_\_\_ ID# \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YY)

Address \_\_\_\_\_ City, \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If a request is being made to send this information to a **third party** please complete the following information.

Third Party Name \_\_\_\_\_ Relationship to Member \_\_\_\_\_

Third Party Address \_\_\_\_\_ City, \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Authorization and/or Personal Representative records need to be on file in order to send information to a third party.**

**If you are an HMO member requesting copies of your clinical medical records, MVP is required to notify your physician of the request, or you may contact your physician's office directly to obtain those records.**

I, the undersigned, hereby request that MVP Health Plan, Inc., MVP Select Care, Inc., MVP Health Insurance Company or MVP Health Services Corp. (collectively "MVP Healthcare") disclose to me the health information identified below:

- \_\_\_\_ 1. Medical claim information for a specific condition (State name of condition here) \_\_\_\_\_
- \_\_\_\_ 2. Medical claim information for a specific date (Specify date here) \_\_\_\_\_
- \_\_\_\_ 3. Medical claim information for a specific period of time: From \_\_\_\_\_ to \_\_\_\_\_
  
- \_\_\_\_ 4. Pharmacy claim information for a specific condition (State name of condition here) \_\_\_\_\_
- \_\_\_\_ 5. Pharmacy claim information for a specific date (Specify date here) \_\_\_\_\_
- \_\_\_\_ 6. Pharmacy claim information for a specific period of time: From \_\_\_\_\_ to \_\_\_\_\_
  
- \_\_\_\_ 7. Dental claim information for a specific condition (State name of condition here) \_\_\_\_\_
- \_\_\_\_ 8. Dental claim information for a specific date (Specify date here) \_\_\_\_\_
- \_\_\_\_ 9. Dental claim information for a specific period of time: From \_\_\_\_\_ to \_\_\_\_\_
  
- \_\_\_\_ 10. Utilization Management information for a specific condition (state name of condition here) \_\_\_\_\_
- \_\_\_\_ 11. Appeals information for a specific case (Specify case# or date of service here) \_\_\_\_\_
- \_\_\_\_ 12. Eligibility/Enrollment information for a specific period of time: From \_\_\_\_\_ to \_\_\_\_\_

Other \_\_\_\_\_

**The following items must be initialed to be included in the disclosure of health information:**

- \_\_\_\_ HIV/AIDS related information and/or records
- \_\_\_\_ Pregnancy/Family Planning related information
- \_\_\_\_ Mental health information and/or records
- \_\_\_\_ Drug/alcohol diagnosis and treatment information

\_\_\_\_\_  
Signature of Member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Requester

\_\_\_\_\_  
Relationship to Member

(Please provide legal documentation if requestor is NOT the member or is NOT the parent of a minor member)

**Send this form to MVP Member Services Department, P.O. Box 2207 Schenectady, NY 12301  
Or Fax to MVP Member Services at 518-386-7700**