For Health Plan Use

# Interoperability Forms for Providers

Interoperability in health care means that doctors and nurses can share and use patient information across different systems and hospitals in a safe and organized way. This is important because having the right information helps patients get the care they need quickly and securely.

Health systems exchange this information using secure technologies called Application Programming Interfaces (APIs). An API allows different computer systems to connect and share data reliably and efficiently.

Your health plan can use the Provider Access Interface to safely share your health information with the doctors and providers who are treating you. This gives your providers quick access to important information, like your medicines, past care, and health information.

By default, your health plan will share most of your health information with your attributed in-network, treating providers through the Provider Access Interface. An attributed provider is a doctor or other healthcare professional who has been identified by your health plan as someone who is actively involved in your care.

## Interoperability Forms

- **INTEROPERABILITY MEMBER OPT OUT FOR PROVIDER API -** You have the right to Opt Out of this default information sharing and can do so by completing the Interoperability Member Opt Out for Provider API consent form.

- **INTEROPERABILITY MEMBER CONSENT FOR PROVIDER API -** We will not share information relating to genetic testing, substance use disorder, mental health, abortion, HIV/AIDs, and sexually transmitted diseases unless you provide written consent using the Interoperability Member Consent for Provider API form.

For additional information on Interoperability please visit our website at https://www.cdphp.com/

**Please keep a copy for your records**

*For Health Plan Use*

# INTEROPERABILITY MEMBER CONSENT FOR PROVIDER API

The purpose of this authorization is to allow Capital District Physicians' Health Plan, Inc. (“Health Plan”) to share your health information with your healthcare providers through the Provider Access API. This authorization also allows you to opt in to the sharing of sensitive diagnosis information and to opt in to general information sharing if you have previously opted out of such sharing.

**Authorization to the Health Plan to Disclose Protected Health Information (PHI) Through the Provider API**

**Section I: Member Information**

| Last Name | First Name | Middle Initial | Date of Birth |
|---|---|---|---|
| Street address | City | State | Zip Code |
| Member Identification Number (located on member ID card) | | | |

**Section II: Opt In After Opt Out**

Complete this section if you are choosing to opt in to general information sharing after previously opting out. By opting in, you authorize the Health Plan to share your general health information with your healthcare providers through the Provider Access API.

_____ By initialing here, I agree to allow the Health Plan to share my protected health information (PHI).

**Section III: Opt In - Sensitive Data**

Complete this section if you are choosing to opt in to the sharing of sensitive data. By opting in, you authorize the Health Plan to share sensitive diagnosis information. **Note:** If signing on behalf of a minor, this authorization applies only to mental health and genetic testing information. Sharing of other listed sensitive conditions requires the minor’s signature.

**Information to Be Disclosed**

_____ By initialing here, I agree to allow the Health Plan to share my protected health information (PHI) for all of the below conditions with my attributed providers:

- Genetic testing information
- Sexually transmitted diseases (STDs)
- Substance use disorder treatment
- Abortion-related information
- Mental health information

**Continued on next page**

## Section III (Continued): Opt In - Sensitive Data

**Note: A separate form must be completed in order to authorize release of information related to HIV/AIDS.** The NYS approved form can be found at: http://www.health.ny.gov/diseases/aids/providers/forms/informedconsent.htm

## Section IV: Acknowledgement (Please read and sign)

I understand that:

- I can revoke this authorization at any time by writing to the Health Plan at the address listed below except this revocation would not affect any action taken by the Health Plan in reliance on this authorization before my written revocation is received.
- Information disclosed as a result of this authorization may be re-disclosed by the recipient. Federal and state privacy laws may no longer protect my PHI.
- Health Plan will not condition my enrollment in a health plan, eligibility for benefits or payment of claims on my giving this authorization.
- This authorization will remain in effect until the Health Plan receives my written cancelation notice, or, until the date I specify here: _____

**IMPORTANT: I have read and understand the terms of this authorization. I hereby authorize the use and disclosure of my protected health information in the manner described in this form.**

**Signature: _____ Date: _____**

**If this request is from a personal representative on behalf of the member, complete the following:**

Personal Representative's Name: _____

Personal Representative's Signature _____ Date: _____
Description of Authority: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney*
☐ Other* _____
** You must provide documentation supporting your legal authority to act on behalf of the member*

**Return To:**
**Capital District Physicians' Health Plan, Inc.**
**P.O. Box 21494**
**Eagan, MN 55121**