



SPOUSE AUTHORIZATION

HEALTH PLAN – CFV ACO/VALLEY CONNECTED CARE PARTICIPATION

CFV EMPLOYEE NAME (please print)	EMPL#
COVERED SPOUSE NAME (please print)	DOB:

**Authorization for
Disclosure and Use of
Protected Health Information
To and By the Cape Fear Valley
Accountable Care Organization (ACO) Care Navigation**

☐ **I DO authorize** ☐ **I DO NOT authorize**

MedCost and/or the administrator of the Cape Fear Valley Health System Medical Plan (the “Plan”) to disclose my Plan enrollment, claims information, and other protected health information to the Cape Fear Valley Accountable Care Organization, LLC (“CFV ACO”). Such information includes Plan payments and other information regarding illnesses, injuries, disabilities and medical and mental health conditions.

The information will be disclosed to CFV ACO so that I may receive ACO Navigation Services. The ACO Navigation Services are designed to provide higher quality and more coordinated services and care to my family and me. The CFV ACO program will include no-cost services to health plan participants, covered spouses and dependents and my information will only be used for these purposes.

This Authorization shall remain in effect until the earlier of my termination of employment with Cape Fear Valley Health System, the time I cease participation in the CFV ACO or a CFV ACO affiliated benefit plan, or the date I revoke this Authorization in writing. I understand that I (or my personal representative) may revoke this Authorization at any time, provided that this Authorization may not be revoked to the extent to which it has been relied upon. To revoke this Authorization, I (or my personal representative) must submit a written notice of revocation to the Plan’s Privacy Officer or its delegate.

Once disclosure of my personally identifiable health information is made pursuant to this Authorization, such information will no longer be subject to the restrictions on use and disclosure applicable under the Plan’s Privacy Policy and the Health Insurance Portability and Accountability Act (“HIPAA”) privacy protections. My information, however, will only be used to help my health care team provide better care through the ACO Navigator Services program.

If you have any further questions about the Cape Fear Valley ACO/Valley Connected Care or Care Navigation Services, please contact the ACO Nurse Navigator at 615-4939.

Fax completed form to Rebecca Bean at 910-615-9791.

Must sign the reverse side of this form



CFV ACO will maintain the privacy and security of my personally identifiable health information and will protect all of my personally identifiable health information from unauthorized access. CFV ACO will never disclose any of my personally identifiable health information either publicly or to my employer. My personally identifiable health information provided in connection with the ACO Navigation Services program will not be provided to my supervisors or managers and may never be used to make decisions regarding my employment.

I understand that my health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the ACO Navigation Services program, and I will not be asked or required to waive the confidentiality of my health information as a condition of participating in the ACO Navigation Services program. Anyone who receives my information for purposes of providing me services as part of the ACO Navigation Services program will abide by the same confidentiality requirements. The only individual(s) who will receive my personally identifiable health information are nurses, physicians, pharmacists or clinical support staff, participating in the ACO Navigation Services program. In addition, all medical information obtained through the ACO Navigation Services program will be maintained separate from my personnel records, information stored electronically will be encrypted, and no information I provide as part of the ACO Navigation Services program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information I provide in connection with the ACO Navigation Services program, CFV ACO will notify me immediately.

There are no costs or penalties for my participation or refusal to participate in the ACO Navigation Services program and I may choose to discontinue services at any time. I understand that if I choose not to take part in Valley Connected Care Wellness Programs, or stop connecting with the program while enrolled, I will no longer qualify for the Wellness Program discount and my medical benefit premiums may be adjusted to the non-discounted rate. I understand that participation in the ACO Navigation Services program will not change health insurance plan benefits, copays or deductibles, nor does it change my ability to choose my providers within the MedCost network.

I understand that I may not be discriminated against in employment because of the medical information I provide as part of participating in the ACO Navigation Services program, nor may I be subjected to retaliation if I choose not to participate. My eligibility to participate in and my eligibility for benefits under the Plan may not be and are not conditioned on whether I sign this Authorization.

SPOUSE Signature	Date
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