

# Senior LinkAge Line® Client Agreement, Authorization for Release of Personal Health Information & Notice of Privacy Practices

## Section A: NOTICE OF PRIVACY PRACTICES Senior LinkAge Line®

This information is available in other forms to people with disabilities by contacting 651-431-2500 or 1-800-882-6262. TDD users can call 711 or 1-800-627-3529. Speech to Speech Relay users can call 1-877-627-3848.

**This notice describes how medical information and other private information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

You have privacy rights under the Minnesota Data Practices Act and the federal Health Insurance Portability and Accountability Act (HIPAA). These laws protect your privacy, but also let us give information about you to others if a law requires it. We may tell you before we give the information to another organization.

### **Why do we ask you for this information?**

Senior LinkAge Line® (SLL) is a statewide information and assistance service for people with Medicare, seniors, caregivers and all people seeking help with reducing their prescription drug expenses. The service is offered by the Minnesota Board on Aging (MBA) and the Area Agencies on Aging (AAA). The Minnesota Department of Human Services has asked us to assist people who are enrolled in public health programs with various needs such as prescription drug expense help. In order for us to assist you, we need to ask you questions about your specific needs.

### **Do you have to answer the questions we ask?**

You can refuse to answer any question we ask. SLL is funded by various grants that have reporting requirements. We ask you the questions in order to best assist you and comply with our reporting requirements. Most of the information we collect from you is reported to our grantors in a report that will not identify you individually and will not be reported by individual.

### **With whom may we share the information about you?**

Your name and other identifying information will not be made public and will remain private. We will not share private information about you with anyone other than the MBA or Minnesota Department of Human Services unless required by law.

### **Why do I need to be notified of this when I called SLL?**

We want you to be aware of what we do with the information we collect from you when assisting you. Even though you are actively seeking help from us and are voluntarily providing this information, we want you to know how the information we collect is used.

### **You have rights regarding your information.**

- You may ask if we have any information about you and get copies. You will have to pay for the copies.
- We will give you a copy of your signed consent form.
- If you do not understand the information, you may ask to have it explained to you.

- You may give other people permission to see and have copies of private data about you, including protected health information (referred to below, collectively, as “protected information”).
- If we have collected protected information about you, we may use it only for the purposes that we have listed in this notice.
- You may question the accuracy of any information we have about you.
- You have the right to ask us to share your protected health information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. You must make this request in writing. If we find that your request is reasonable, we will grant it.
- You can ask us to restrict uses or disclosures of your protected health information. Your request must be in writing. You must explain what information you want to restrict from being disclosed and to whom you want these restrictions to apply. You can request to end these restrictions at any time by calling or writing to us.
- You have the right to receive a record of certain types of disclosures of your health information. We must keep a record of certain disclosures of your health information for six years from the date it was shared. We must keep a record of each time we share your health information for six years from the date it was shared. If you want a copy of this record, you must send a request in writing to the Privacy Official listed below.

### **What if you believe the information we have about you is wrong?**

Send your concerns in writing, telling us why the information is not accurate or complete. You may send your own explanation which will be attached any time that information is shared with another agency.

### **What if you believe your privacy rights have been violated?**

You may complain if you believe your privacy rights have been violated. You cannot be denied service or treated badly because you have made a complaint. If you believe that your doctor, clinic, a health insurer, a health plan, or a pharmacy violated your medical privacy, you may send a written complaint either:

- Directly to that organization, *or*
- To the federal Office of Civil Rights at:

Office of Civil Rights  
 U. S. Department of Health and Human Services  
 233 N. Michigan Ave., Suite 240  
 Chicago, IL 60601  
 Voice phone: 312-886-2359  
 FAX: 312-886-1807 TDD: 312-353-5693

If you think the SLL or AAA or MBA have violated your privacy rights, you may send a written complaint to the U.S. Department of Health and Human Services at the address above, or to:

Attn: Privacy Official  
 Minnesota Board on Aging  
 PO Box 64976.  
 St. Paul, MN 55164-0976

### **Section B: What It Means to Receive Assistance from SLL Client Agreement Form**

I understand that:

- SLL is a service of the MBA administered in my community by the AAA.
- This service is intended to provide information and assistance to me regarding Medicare, Medicare Supplements, Medical Assistance, Long-term Care Insurance, Medicare Advantage, Medicare Part D coverage, and other benefit programs and options so I will be informed of viable choices, exercise my individual rights and protections, and become a pro-active partner in my own health care and long-term care planning decisions.

- The information and assistance is provided to me by trained staff, contractors or volunteers, who are acting in good faith, and information given shall not be construed as legal advice.
- SLL staff, contractors and volunteers do not sell, recommend, or endorse any specific insurance product, agent, company, Medicare Advantage or Private Prescription Drug Plan, membership organization, nor may they be actively affiliated with the insurance, financial planning or pharmaceutical industry.
- SLL staff, contractors and volunteers assume no responsibility for decisions made or actions taken by me. I hold harmless the Minnesota SLL and staff, contractors and volunteers for any liability arising out of services provided within the program guidelines.

Finally, I understand that by signing Section D:

- I am acknowledging that the understandings and assurances above have been explained to me, and
- I am agreeing to all of the provisions and guidelines of the Minnesota SLL.

### **Section C: Authorization (Statement of Consent) to Obtain and Share My Private Information**

I understand that, in order for the SLL to help me, they will need to collect and share private and personal information about me, including information about my health.

The SLL staff, contractors and volunteers will use information collected only to assist me and will not divulge private and confidential data to external sources other than Centers for Medicare and Medicaid Services (CMS), Administration on Community Living (ACL), Office of Inspector General (OIG), MBA, Minnesota Department of Human Services and other appropriate state agencies, AAA, Disability Hub MN, Veterans Linkage Line™ and

service providers or insurance carriers in conjunction with counseling or assistance duties.

I know that state and federal privacy laws protect my records. I also know that my private health information can generally be released only if I give my written permission or if the law allows it. If I sign an authorization to allow the sharing of private and personal information about me, including information about my health, I do so with full understanding of the following facts and consequences:

- The MBA, AAA and SLL makes every effort to protect and secure my information
- That, generally, I must give my written consent for MBA, AAA and SLL to give out the information.
- If I do not consent, the information will not be released unless the law otherwise allows or requires it.
- If I do not consent, MBA, AAA and SLL may not be able to fully assist me.
- I may stop this consent with a written notice at any time, but this written notice will not affect information the agency already has released.
- The person or agency who gets my information may be able to pass it on to others.
- If my information is passed on to others by MBA, AAA and SLL, it may no longer be protected by this authorization.
- This consent will end one year from the date I sign it, unless the law allows for a longer period.

I know why I am being asked to release this information. By signing Section D and Attachment 1, I agree to authorize the program and/or the below named individual to receive and transmit information as necessary from/to my hospitals, physicians and/or other providers of medical services or supplies as well as Medicare Administrative Contractors and my private insurance companies.

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**Section D: Acknowledgment of Receipt of Notice of Privacy Practices, Agreement to Program Terms & Conditions, and Authorization for Sharing of Personal and Private Information**

I have read this entire form or have had it explained to me and I understand its contents. I have been given the chance to ask questions about the Minnesota Board on Aging, Area Agencies on Aging and Senior LinkAge Line® and all of my questions have been answered to my satisfaction.

**Effect of Signing This Form**

By signing below I am:

1. Acknowledging receipt of the Notice of Privacy Practices which was explained to me in Section A
2. Acknowledging that I have been provided the chance to ask questions and any questions have been answered and agreeing to the terms and conditions set forth above in this form and in Section B
3. Authorizing the release of private data including Personal Health Information about me as set forth in Section C

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Participant Signature

Date

Participant Printed Name

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Date of Birth

Zip Code

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Person Authorized to Sign

Date

Relationship to Person Authorized to Sign

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Witness to Signature

Date

Principal Staff Signature

# GENERAL CONSENT & AUTHORIZATION FOR RELEASE OF INFORMATION: Attachment 1

To be completed by the person giving consent/authorization (please print): \_\_\_\_\_

*(This information is being requested solely to verify the identity of the person giving consent/authorization.)*

NAME		
ADDRESS		
CITY	STATE	ZIP CODE
Telephone number		

**Consequences:** I know that state and federal privacy laws protect my records. I know:

- The Minnesota Board on Aging, Area Agencies on Aging and Senior LinkAge Line<sup>®</sup> makes every effort to protect and secure my information
- Why I am being asked to release this information
- I do not have to consent to the release of this information
- That, generally, I must give my written consent for Minnesota Board on Aging, Area Agencies on Aging and Senior LinkAge Line<sup>®</sup> to give out the information.
- If I do not consent, the information will not be released unless the law otherwise allows or requires it.
- If I do not consent, Minnesota Board on Aging, Area Agencies on Aging and Senior LinkAge Line<sup>®</sup> may not be able to fully assist me.
- I may stop this consent with a written notice at any time, but this written notice will not affect information the agency already has released.
- The person or agency who gets my information may be able to pass it on to others.
- If my information is passed on to others by Senior LinkAge Line<sup>®</sup>, it may no longer be protected by this authorization.
- This consent will end one year from the date I sign it, unless the law allows for a longer period.

**Authorization/Consent:** By signing below, I authorize Minnesota Board on Aging, Area Agencies on Aging and Senior LinkAge Line<sup>®</sup> to release the following information about me:

- Identifying information so Minnesota Board on Aging, Area Agencies on Aging and Senior LinkAge Line<sup>®</sup> can provide me comprehensive assistance.
- OTHER: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The information will be released to:

Name of agency: \_\_\_\_\_  
Contact person: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_  
Zip Code: \_\_\_\_\_

CLIENT SIGNATURE or SIGNATURE OF PARENT/GUARDIAN/AUTHORIZED REP

Date: