MEPS AF Booklet Interior text

…information released to MEPS is protected by the Public Health Service Act…

[image of blank hospital stay form]
Q. Why do you need this form?
A. Health care information you share with your doctor or pharmacist is private. Your providers cannot release information about you to a study like MEPS without your written authorization. In 2003, a Federal law (the Health Insurance Portability and Accountability Act, or HIPAA for short) created new and stronger standards for protecting health care information. Your providers may have told you about some of these new requirements. One section of the law sets guidelines for the authorization forms that must be signed to allow a provider to release health care information. The MEPS authorization form follows these guidelines.

Q. What about privacy?
A. The law authorizing MEPS requires that all information collected for the study that identifies an individual person or medical provider must be kept strictly confidential and private to the extent permitted by law. Just like the information you have already given to the MEPS interviewer, any information your provider gives us will be protected by Federal law under, Sections 934(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 242m(d)]. This law prohibits the release of personal information outside the public health agencies sponsoring the survey and their contractors unless they have first obtained permission from the person who gave the information.

[image of blank pharmacy form]
The new HIPAA law creates additional protection for personal health information held by medical providers and pharmacies. But HIPAA protections end when the information is released to others. When information is released to MEPS, the requirements of the Public Health Service Act provide continuing assurance of confidentiality.

For specific information about these laws, refer to:
The Health Insurance Portability
and Accountability Act: 45CFR164.508.

The Public Health Service Act: Section 924(c)
and 308(d) [42 U.S.C. 299c-3(c) and 242m(d)],
and 42 U.S.C. 290dd-2, 42 CFR Part 2.

More Questions & Answers

Q. **My providers are very busy. Isn't this a bother to them?**
A. Your signature on an authorization form simply Gives your doctor, hospital, or pharmacy the opportunity to participate in the study if they choose. It allows them to make their own decisions. Our experience indicates that most health care providers are willing to participate in important research such as MEPS. Usually, an office staff person can fill out the form and the pharmacist can produce a simple computer printout.

Q. **What information will you tell my doctor (or pharmacist) about me?**
A. To allow medical and pharmacy staff to identify your records, we will provide your name, date of birth, and the signed authorization form. We also will share other information such as your address or name of the policyholder for your health insurance, if needed, to help a doctor or hospital identify the correct records.

Q. **Will this affect my Medicare, Medicaid, VA benefits, or any other public assistance I am receiving?**
A. No. Signing or not signing this authorization form will not affect your eligibility for any program benefits.

Q. **Why do you need to contact my psychiatrist? That informationis too personal.**
A. Should they choose to participate in the study, psychiatrists like other doctors, will be asked about the costs, dates, diagnoses, and type of service they provide. They will not be asked about treatment details.

Q. **Why does this form have an expiration date that is past the period of time you are interested in?**
A. This is only to allow enough time for contact with all of the health care providers in this survey. Large surveys such as this take time.

*Research groups use the results of this survey in their attempts to improve access to medical care for older people, veterans, minorities, and children.*

Q. **Will my doctor (or pharmacist) bill me for the time he or she spent participating in this survey?**
A. No. Should a doctor, hospital, or pharmacy have a policy of charging for the information we request, MEPS will pay this charge directly.

Q. **My children have advised me not to sign anything. Why should I?**
A. A vital part of the research is directed at understanding the special health care needs of older Americans. Many research groups use the results of this survey in their attempts to improve access to medical care for older people. We understand that your children only want to protect you. If they have a particular concern that we could address, the interviewer will be happy to talk to them or they can call Alex Scott at 1-800-945-MEPS (6377).

Q. **Can I sign the authorization form for my husband (wife, or child)?**
A. Authorization forms must be signed by the personwho received the services from the provider or pharmacy named in Box A of the authorization form. However, a parent or guardian must sign an authorization form for a child age 13 or younger. For teens between 14 and 17 years of age, two signatures are required — the teen AND the parent/guardian.

Q. **What if I change my mind?**
A. You can revoke an authorization at any time by contacting the MEPS study. You can contact the study by telephone by calling 1-800-945-MEPS (6377). You can contact the study by mail at the following address:
Medical Expenditure Panel Survey
ATTN: Alex Scott
c/o Westat
1650 Research Blvd. Room 358
Rockville, MD 20850
If you decide to revoke an authorization, we will stop any efforts to contact that provider. If the provider has already given us information about you, we will erase that information from the study records unless it is already incorporated into research files in which you cannot be identified.

Authorization Forms Instructions
[image of sample authorization form filled out with proxy information]

***Please follow these instructions as you review and sign authorization forms in black ink.***

**A,**
**Check the name and address of the hospital, pharmacy, or other medical provider.**
If any of this information is not correct, please make changes and initial each correction.

**B.**
**Read the statement.**
(See enlargement on facing page.)

**C.**
**Check the patient's name and date of birth.**
If any of this information is not correct, please make changes and initial each correction.
If your records might be filed under some other name (a maiden name or alternate spelling, for example), please complete Item 3.

**D. & E.**
**Who should sign the form?**

| IF PATIENT IS: | THEN FORM SHOULD BE SIGNED BY: |
|---|---|
| a. Age 18 or older | Only patient for Items 4 and 5, unless one of d-f below applies |
| b. Age 14 through 17 | Patient and parent or guardian (Items 4-9) |
| c. Age 13 or younger | Parent (Items 6-9) |
| d. Unable to sign name but able to make mark | Witness (Items 6-9) |
| e. Deceased | Proxy (Items 6-9) |
| f. Unable to sign name or make mark | Proxy (Items 6-9) |