Form F1A: Authorization to Release Psychotherapy Notes

INSTRUCTIONS: You must complete all information below. If incomplete, this authorization will be returned. If you have any questions or need assistance completing this form, please contact Customer Service at (800) 247-2583. This form consists of three (3) pages.

Section 1: Member Information

Member Name: _____ Date of Birth: _____

Identification Number: _____ Telephone: _____

Address: _____

_____

Section 2: Purpose

I authorize Blue Cross and Blue Shield of Vermont (BCBSVT), The Vermont Health Plan (TVHP), Vermont Collaborative Care (VCC), and their subsidiaries, affiliates, employees, officers, agents and other related entities to give psychotherapy notes to the authorized person(s) named in Section 4. I have requested this information to be given to the authorized person(s) for the purpose of responding to an inquiry regarding my health benefits.

Psychotherapy notes are notes created by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.

Section 3: Important Information about this Authorization to Release Psychotherapy Notes

Indemnity—I hereby release BCBSVT/TVHP, VCC and their its subsidiaries, affiliates, employees, officers, agents and other related entities from any and all liability associated with the release of such information and records to the authorized person, and further agree to indemnify and hold BCBSVT/TVHP harmless, and defend BCBSVT/TVHP in court, if necessary, from any claims arising out of any release of information pursuant to this authorization.

Voluntary Authorization—This authorization is voluntary. BCBSVT/TVHP will not condition my enrollment, eligibility for benefits or payment of claims on giving this authorization.

Re-disclosure of Information—I understand that the authorized person(s) who receives my protected health information under this authorization may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

General Health Care Information—I understand that this authorization is limited solely to the release of psychotherapy notes and does not provide for the release of any other health care information. I understand that I *must complete a separate form*, Authorization to Release Information, for this purpose.

I understand that Psychotherapy Notes may include medical information and information relating to alcohol or substance abuse, HIV/AIDS and/or sexually transmitted disease(s).

Section 4: Authorized Person(s) – authorization may only be granted to an individual not to an organization.

Provide the information below for each person that is authorized to receive your protected health information identified above. Please include a complete address and specify the relationship to the member. Please print.

Name:_____
Organization (if applicable):_____
Address:_____
Street or Post Office Box

_____
City State Zip Code
Telephone:_____
Relationship to Member:_____
i.e. mother, attorney, neighbor, friend, benefits administrator

Name:_____
Organization (if applicable):_____
Address:_____
Street or Post Office Box

_____
City State Zip Code
Telephone:_____
Relationship to Member:_____
i.e. mother, attorney, neighbor, friend, benefits administrator

Section 5: Expiration
Unless revoked, this authorization is valid from the date of my signature until the date I am no longer insured by BCBSVT or TVHP or upon the date written below (if any), whichever occurs first. This authorization will automatically terminate upon my death.

This authorization shall terminate on (specify date, if applicable) _____. *

*Pursuant to Vermont law, any authorization concerning a minor under the age of twelve will automatically expire upon the minor's twelfth birthday. The minor may complete an authorization upon such expiration.

Section 6: Revocation
I understand that I may revoke this authorization at any time by mailing *written* notice of my revocation to Blue Cross and Blue Shield of Vermont ATTN: Privacy Officer at PO Box 186 Montpelier, VT 05601. I understand that revocation of this authorization will *not* affect any action BCBSVT/TVHP, VCC and their subsidiaries, affiliates, employees, officers, agents, and other related entities took in reliance on this authorization before it received my written notice of revocation.

Section 7: Signature
I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to BCBSVT/TVHP. I understand that, by signing this form, I am confirming my authorization that BCBSVT/TVHP, VCC and their subsidiaries, affiliates, employees, officers, agents and other related entities may use and/or disclose the protected health information described in this form to the authorized person(s) named above.

Member Signature**:_____ Date: _____

**If the Member is a minor aged 12 through 18, he/she must authorize the release of certain protected health information even if a parent or legal guardian is requesting the information. If the authorized person is anyone other than the parent or legal guardian, and the authorization is for the release of information *other than* treatment for mental health, substance abuse and/or sexually transmitted disease, the parent or legal guardian must also sign this authorization. The parent or legal guardian should sign as a personal representative, below.

If you are a personal representative, such as a Legal Guardian or agent acting under a Power of Attorney, you *may* be able to sign on behalf of the Member/Patient if the supporting paperwork has required regulatory language. Complete the following and attach documentation (if applicable) supporting such personal representation and our Legal department will determine whether it is sufficient to grant authorization:

Personal Representative's Name: _____

Relationship to Member or Authority to act as Personal Representative: _____

Please keep a copy of this document for your records and mail the completed Authorization to Blue Cross and Blue Shield of Vermont, Attn: Customer Service, PO Box 186, Montpelier, VT 05601-0186. Or fax to (802) 371-3658.