Form F1: Authorization to Release Information

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: Important Information about this Authorization to Release Information

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 the information listed in Section 3 below 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 inquiries regarding my health benefits.

Indemnity—I hereby release BCBSVT, TVHP, VCC and their 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.

Psychotherapy Notes—I understand that this authorization does not provide for the release of psychotherapy notes and that I *must complete a separate form*, Authorization to Release Psychotherapy Notes, for this purpose. 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.

Substance Abuse Treatment Records—I understand that this authorization does not provide for the release of substance abuse treatment records and that I *must complete a separate form*, Authorization to Release Substance Abuse Treatment Records, for this purpose. Substance Abuse Treatment Record means any information, whether recorded or not, that might identify an individual, directly or indirectly, as having or having had a substance abuse disorder. For

example, any document containing the identity, diagnosis, prognosis, or treatment of any patient relating to substance abuse education, prevention, training, treatment, rehabilitation, or research.

Section 3: Protected Health Information
Please check one of the boxes below. If you do not select anything, BCBSVT/TVHP will release General Health Care Information as described below.

- ❑ General Health Care Information—BCBSVT/TVHP may disclose to the authorized person(s) all of the information and records that could be given to me upon my request. This may include medical and mental health information and information relating to treatment for sensitive issues such as HIV/AIDS and/or sexually transmitted disease(s).
    - Please note that for authorization to release psychotherapy notes or substance abuse treatment records, you must sign additional authorizations. Please see BCBSVT Forms 1A 1C, 1D and 1E.

- ❑ Other—(Please be specific. You may identify information by date of service, name of provider, or specific diagnosis): _____

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) _____. *

*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 and VCC.

I understand that, by signing this form, I am confirming my authorization that BCBSVT TVHP and VCC 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 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 email the Authorization to Blue Cross and Blue Shield of Vermont, Attn: Privacy Officer, at CustomerService@bcbsvt.com.

NOTE: This form must be signed by the Member granting the permission; not the person receiving the permission. If intending to submit with an electronic signature, this form must be sent by the member granting the permission.

Form F1D: Authorization to Release Substance Abuse Treatment Records

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: Consent

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 substance abuse treatment records 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 inquiries regarding my health benefits.

Substance Abuse Treatment Records include any information, whether recorded or not, that might identify an individual, directly or indirectly, as having or having had a substance abuse disorder. For example, any document containing the identity, diagnosis, prognosis, or treatment of any patient relating to substance abuse education, prevention, training, treatment, rehabilitation, or research.

Section 3: Important Information about this Authorization to Release Substance Abuse Records

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 BCBSVT/TVHP, VCC and their its subsidiaries, affiliates, employees, officers, agents and other related entities have no control over the authorized person(s) or entities whom I have authorized to receive my protected health information. Therefore, BCBSVT/TVHP, VCC and their its subsidiaries, affiliates, employees, officers, agents and other related entities shall not be responsible for any improper or unauthorized re-disclosure of my information by those authorized under this document.
General Health Care Information—I understand that this authorization is limited solely to the release of substance abuse records 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 substance records may include medical information and information relating to sensitive issues such mental health, HIV/AIDS and/or sexually transmitted disease(s).

Section 4: Nature and Amount of Information
Please check one of the boxes below. If you do not select anything, BCBSVT/TVHP will release General Substance Abuse Treatment Information as described below.

- ❑ General Substance Abuse Treatment Information—BCBSVT/TVHP may disclose to the authorized person(s) all of the information and records that could be given to me upon my request.
- ❑ Other—(Please be specific. You may identify information by date of service, name of provider, treatment facility, or specific prognosis/diagnosis):

Section 5: Authorized Recipient(s)
Provide the information below for each person/entity 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. treating provider, third party payer, 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. treating provider, third party payer, mother, attorney, neighbor, friend, benefits administrator

General Designations: If you have provided is a general designation of an individual or entity participant(s) or class of participant(s) (ie. my treating providers), then you may request a list of entities to which your information has been disclosed.

Section 6: Purpose
The purpose of this disclosure is to

Section 7: 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 8: Revocation
I understand that I may revoke this authorization at any time, except when a lawful holder of my information has acted in reliance of this document. I understand that my request to revoke this authorization may be made 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 9: 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: _____

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Please keep a copy of this document for your records and email the completed Authorization to Blue Cross and Blue Shield of Vermont, Attn: Privacy Officer, at CustomerService@bcbsvt.com.

NOTE: This form must be signed by the Member granting the permission; not the person receiving the permission. If intending to submit with an electronic signature, this form must be sent by the member granting the permission.