Form F1: Authorization to Release Information

INSTRUCTIONS: This authorization is intended for currently enrolled members. If you are a former member, or acting on behalf of a deceased member, please complete one of the following: Form F1A: Authorization to Release Information Following Termination of Coverage, Form F17: Affidavit of Surviving Spouse, or Form F18: Affidavit of Next of Kin. 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 four (4) pages.

Section 1: Member Information

Member Name: _____ Date of Birth: _____

BCBSVT ID Number: _____

Address: _____

_____

Telephone: _____ E-Mail 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*, Form F1B: Authorization to Release Psychotherapy Notes (or F1C: Authorization to Release Psychotherapy Notes Following Termination of Coverage), 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 Use Disorder (SUD) Records—I understand that this authorization does not provide for the release of SUD records and that I *must complete a separate form*, Form F1D: Authorization to Release Substance Use Disorder (SUD) Records (or F1E: Authorization to Release Substance Use Disorder (SUD) Records Following Termination of Coverage), for this purpose. SUD Records means any information, whether recorded or not, that might identify an individual, directly or indirectly, as having or having had a substance use disorder. For example, any document containing the identity, diagnosis, prognosis, or treatment of any patient relating to SUD education, prevention, training, treatment, rehabilitation, or research.

Section 3: Protected Health Information
Please check one or multiple 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 protected health 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).
    - Note: for authorization to release psychotherapy notes or substance use disorder (SUD) records, you must sign additional authorizations. Please see BCBSVT Forms 1A 1C, 1D and 1E.

- ❑ Member Resource Center (MRC) Portal – members may elect to access their protected health information via the MRC. BCBSVT may permit the authorized person(s) to receive information on my behalf through the MRC portal, including the ability to set up an account or change the password to the MRC portal on my behalf, that I would be able to do on my own behalf, pursuant to 14 V.S.A. Chapter 125 (Vermont Revised Uniform Fiduciary Access to Digital Assets Act).
    - Every member age 12 or older must create their own username and password.
    - The MRC includes specific Terms and Conditions of Use which details how BCBSVT maintains the privacy of information located or obtained on the MRC.
    - Note: the MRC portal gives members the option of allowing another person on their same policy to access (limited) information within your MRC portal. You may use the "My Permissions" tool within the portal to permit access to another person on your policy.

- ❑ Other— I would like to limit the information BCBSVT discloses on my behalf to the individual(s) designated below. (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:_____	Name:_____
Organization (if applicable):_____	Organization (if applicable):_____

Address:_____
Street or Post Office Box

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

Address:_____
Street or Post Office Box

_____
City State Zip Code
Telephone:_____
E-Mail:_____
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, authorization concerning a minor under the age of 12 will automatically expire upon the minor's 12th 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 or e-mailing a completed Form F2: Revocation of Authorization to Release Information or an otherwise *written* notice of my revocation to Blue Cross and Blue Shield of Vermont ATTN: Privacy Officer at PO Box 186 Montpelier, VT 05601, or privacyofficer@bcbsvt.com. 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 age 12 or older (12 – 18 years old) , they must authorize the release of certain protected health information even if a parent or legal guardian is requesting the information. If an authorized person listed above is not a parent or legal guardian, and the authorization is for information *other than* treatment for mental health, substance use disorder (SUD), or sexually transmitted disease, the parent or legal guardian must also sign this authorization as a personal representative below.

If you are a personal representative, such as a Legal Guardian or an agent acting under a Power of Attorney, you *may* be able to sign on behalf of the Member if the supporting documentation has the required language. This Form shall be accompanied by such supporting documentation for BCBSVT's Legal Department to determine whether authority is granted to authorize this Form.

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 send the completed Authorization via mail to Blue Cross and Blue Shield of Vermont, Attn: Customer Service, PO Box 186, Montpelier, VT 05601-0186, fax to (802) 371-3658, or email customerservice@bcbsvt.com.

NOTE: This form must be signed and sent by the Member granting the permission, not the person receiving the permission.

Form F1D: Authorization to Release Substance Use Disorder (SUD) Records

INSTRUCTIONS: This authorization is intended for currently enrolled members. If you are a former member, or acting on behalf of a deceased member, please complete Form F1E: Authorization to Release Substance Use Disorder (SUD) Records. 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 four (4) pages.

Section 1: Member Information

Member Name: _____ Date of Birth: _____

BCBSVT ID Number: _____

Address: _____

Telephone: _____ E-Mail 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 use disorder (SUD) 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.

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

NOTICE: Consent for Civil Criminal, Administrative, or Legislative Proceedings

- ❑ Please check this box if this authorization is for the purpose of using or disclosing your SUD records in a civil, criminal, administrative, or legislative proceeding.

  If BCBSVT receives a subpoena requesting my information including SUD records, I understand that I must provide this separate authorization permitting the disclosure of my SUD records before BCBSVT may provide the requested information.

  - The information to be disclosed pursuant to this authorization must be identified in a specific and meaningful manner in Section 4. I understand that failure to do so will result in this authorization being rejected and potential delays.
  - The recipients of the information must be specifically identified under Section 5. I understand that failure to do so will result in this authorization being rejected and potential delays.

By selecting the box above, I authorize the use and disclosure of my SUD records for a legal investigation or proceeding involving or against me. I understand that this authorization applies solely to my SUD records and does not extend to any other protected health information. I understand that this authorization may not be combined with consent for other uses or disclosures of my SUD records, except as it pertains to this matter.

Section 3: Important Information about this Authorization to Release SUD Records

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 BCBSVT/TVHP, VCC and their 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 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 SUD records and does not provide for the release of any other health care information. I understand that I *must complete a separate form*, Form F1: Authorization to Release Information (or Form F1A: Authorization to Release Information Following Termination of Coverage), for this purpose.

I understand that SUD records may include medical information and information relating to sensitive issues such mental health, HIV/AIDS 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 SUD Information as described below.

- ❑ General SUD 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. If you indicated above that this form is for the purpose of providing Consent for Civil Criminal, Administrative, or Legislative Proceedings, you must identify the SUD information in a specific and meaningful fashion:_____
  _____

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:_____
E-Mail:_____
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:_____
E-Mail:_____
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. Note: a general designation is not permitted if you indicated that this form is for the purpose of providing Consent for Civil Criminal, Administrative, or Legislative Proceedings.

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 12 will automatically expire upon the minor's 12th 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 or e-mailing a completed Form F2: Revocation of Authorization to Release Information or an otherwise *written* notice of my revocation to Blue Cross and Blue Shield of Vermont ATTN: Privacy Officer at PO Box 186 Montpelier, VT 05601, or privacyofficer@bcbsvt.com. 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 age 12 or older (12 – 18 years old), they must authorize the release of certain protected health information, such as SUD records, even if a parent or legal guardian is requesting the information.

If you are a personal representative, such as a Legal Guardian or an agent acting under a Power of Attorney, you *may* be able to sign on behalf of the Member if the supporting documentation has the required language. This Form shall be accompanied by such supporting documentation for BCBSVT's Legal Department to determine whether authority is granted to authorize this Form.

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 send the completed Authorization via mail to Blue Cross and Blue Shield of Vermont, Attn: Customer Service, PO Box 186, Montpelier, VT 05601-0186, fax to (802) 371-3658, or email customerservice@bcbsvt.com.

NOTE: This form must be signed and sent by the Member granting the permission, not the person receiving the permission.