Form F1A: Authorization to Release Information Following Termination of Coverage

INSTRUCTIONS: This authorization is intended for former members or on behalf of deceased members. If you are a currently active member, please complete Form F1: Authorization to Release Information. 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) and 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 an inquiry 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 1B, 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:_____	Address:_____

Street or Post Office Box

_____

City State Zip Code

Telephone:_____

E-Mail:_____

Relationship to Member:_____

i.e. mother, attorney, neighbor, friend, benefits administrator

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 one year from the date of execution of this form 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. 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 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 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.