# Form FEP1C: Authorization to Release Psychotherapy Notes Following Termination of Coverage

INSTRUCTIONS: This authorization is intended for former BCBSVT Federal Employee Program (FEP) members or on behalf of deceased FEP members. If you are a currently active FEP member, please complete Form FEP1B: Authorization to Release Psychotherapy Notes. 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 FEP Customer Service at (800) 328-0365. For Postal Service Health Benefit members, please contact (800) 437-6298.

Section 1: Member Information					
Member Name: Date of Birth:					
BCBSVT ID Number:					
Address:					
Telephone:	E-Mail Address:				

## **Section 2: 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 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 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*, Form FEP F1: Authorization to Release Information (or <u>Form FEP F1A</u>: Authorization to Release Information Following <u>Termination of Coverage</u>), for this purpose.

I understand that Psychotherapy Notes may include medical information and information relating to alcohol or substance use disorder (SUD), 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:		Name:Organization (if applicable):Address:			
	Street or Post Office Box			Street or Post Office Box	
City	State	Zip Code	City	State	Zip Code
Telephone:			Telephone:		
E-Mail:			E-Mail:		
Relationship	to Member:		Relationship	to Member:	
i.e., mother, attorney, neighbor, friend, benefits administrator			i.e., mother, a	ttorney, neighbor, friend, b	penefits

#### **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.

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This authorization shall terminate on	(specify date, if applicable)	^

#### **Section 6: Revocation**

I understand that I may revoke this authorization at any time by mailing or e-mailing a completed <u>Form FEP F2</u>: <u>Revocation of Authorization to Release Information</u> or an otherwise <u>written</u> 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

<sup>\*</sup>Pursuant to Vermont law, any authorization concerning a minor under the age of 12 will automatically expire upon the minor's 12<sup>th</sup> birthday. The minor may complete an authorization upon such expiration.

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, 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 of certain protected health information, i.e., psychardian is requesting the information.	
If you are a personal representative, such as a L Power of Attorney, you <i>may</i> be able to sign on be documentation has the required language. This led documentation for BCBSVT's Legal Department to authorize this Form.	behalf of the Member if the supporting  Form shall be accompanied by such supporting
Personal Representative's Name:	
Relationship to Member or Δuthority to act as Pe	ersonal Renresentative

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: FEP Customer Service, PO Box 186, Montpelier, VT 05601-0186, fax to (802) 225-7700, or email FEPcustomerservice@bcbsvt.com.

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