

## Form F1C: Authorization to Release Psychotherapy Notes Following Termination of Coverage

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.

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### Section 1: Member Information

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Identification Number: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_

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### 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*, Authorization to Release Information, for this purpose.



\*\*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.**