# 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 3 pages.

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**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) and The Vermont Health Plan (TVHP), its subsidiaries, affiliates, employees, officers and agents including, but not limited to, Express Scripts and Vermont Collaborative Care 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, its subsidiaries, affiliates, employees, officers and agents including, but not limited to, Express Scripts and Vermont Collaborative Care 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.

**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 alcohol or substance abuse, HIV/AIDS and/or sexually transmitted disease(s).
- ☐ 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) __________________. *

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*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, its subsidiaries, affiliates, employees, officers and agents including, but not limited to, Express Scripts and Vermont Collaborative Care 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, its subsidiaries, affiliates, employees, officers and agents including, but not limited to, Express Scripts and Vermont Collaborative Care 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, and the authorization is for information *other than* treatment for mental health, substance abuse and/or sexually transmitted disease, the parent must also sign this authorization. The parent 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.**

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