AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION AND DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

Note: If you are a physician with offices in Pennsylvania, please see the Highmark Authorization Form found on Navinet.

SECTIONS A-E. Purpose: This form is used for an individual to authorize use or disclosure of the individual's protected health information for the purposes stated.

SECTION A: Psychotherapy notes or substance abuse records.

☐ Check if this authorization is for psychotherapy notes. Psychotherapy Notes are notes that a mental health professional makes, in any medium, that document or analyze the contents of conversations during private, group, joint or family counseling sessions and that are separated from the rest of the individual's medical record. Excludes medication, prescription, monitoring; counseling session start and stop times; treatment modalities and frequencies; clinical test results; diagnosis, functional status, treatment plan, symptoms, prognosis, or progress summary.

If this authorization is for psychotherapy notes, it must *not* be used as an authorization for any other type of protected health information.

☐ Check if this authorization is to include substance abuse records.

SECTION B: Individual authorizing use and/or disclosure.

Patient's Name: ______________________________

Address: ______________________________

Telephone: ____________________

Identification Number: ____________ Social Security Number: ____________

Authorizing Individual (if different than patient): ______________________________

Relationship to the Patient: ______________________________

Address: ______________________________

Telephone: ____________________

If you have not already provided us with the appropriate legal documents supporting your personal representative status, please submit these documents with the form.

TO THE INDIVIDUAL: Please Read.

Conditions: This authorization is voluntary. Except as noted, we will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on receiving this authorization. Refusal to sign the authorization will in no way jeopardize your right to obtain present or future treatment. NOTE: Refusal to sign this authorization, if

Approved by Legal: ____________________

Date: ____________________

requested before your enrollment for the purpose of *pre-enrollment* underwriting, risk rating, or eligibility determinations (provided the authorization is not for Psychotherapy Notes), could result in denial of enrollment.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not subject to federal health information privacy laws. Where appropriate or as required by law, these persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION C: The use and/or disclosure being authorized.

Purpose of this Authorization:

☐ At request of individual (or the individual's personal representative).

☐ For the following purposes:

____

____

Protected Health Information to Be Used and/or Disclosed: Specifically and meaningfully describe the protected health information that this authorization will allow to be used and/or disclosed:

____

____

Individuals/Entities Authorized to Use or Disclose: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who will be authorized to make use of and/or to disclose the protected health information described above:

______________________________ ______________________________

______________________________ ______________________________

Individuals/Entities Authorized to Receive and Use: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, whom this authorization will allow to receive and use the protected health information described above:

______________________________ ______________________________

______________________________ ______________________________

SECTION D: Expiration and revocation.

Expiration: **Complete One:**

☐ This authorization will expire on _____/_____/_________

☐ Time period authorization is valid: From ________________________ To ________________________

☐ This authorization will expire on occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

____

____

Right to Revoke: You (or your personal representative) may revoke this authorization at any time, except to the extent Mountain State Blue Cross and Blue Shield (MSBCBS) has already acted in reliance on it, by giving written notice of revocation, or verbal notification for substance abuse, to the Contact Office listed below. Revocation of this authorization will *not* affect any action we took in reliance on this authorization before we received your verbal or written notice of revocation.

MSBCBS Privacy Office
Address: 700 Market Square Parkersburg, WV 26102
Telephone: (304) 424-9026 Fax: (304) 424-0322
E-mail: MSBCBSPrivacyOffice@msbcbs.com

SECTION E: Individual's Signature.

I, __ ___________, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form, subject to MSBCBS' approval.

Signature: ____ Date: ______________________________

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name (authorizing individual per Section B): __________________________________

Relationship to Individual and/or description of authority to act for individual: ____________________________

REMINDER: If you have not already provided us with the appropriate legal documents supporting your personal representative status, please submit these documents with the form.

<u>SECTION F.</u> Purpose: This form is used for the designation of an authorized representative to act on behalf of a member for purposes of appeals. This section is necessary if you want an individual to not only use, disclose or receive Protected Health Information (Sections A-E), but to make decisions on your behalf for appeals.

<u>SECTION F: Designation of an Authorized Representative.</u>

I, _____________ (*individual identified in Section B above*) do hereby authorize ____________________

__(*name of individual indicated in Section C above to use, receive and disclose Protected Health Information*)

to act as my authorized representative to participate on my behalf for the following claims or matters regarding the following illness, injury or diagnosis:

____

____

____

Signature: ______________________________ Date: ___________________________

INDIVIDUAL IS ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER IT IS SIGNED.

Please send completed form to:

MSBCBS Legal Department
Address: 700 Market Square Parkersburg, WV 26102
Telephone: (304) 424-7711 Fax: (304) 424-9875