Authorization for Behavioral Health Providers to Release Medical Information

This authorization is at my request to permit the release of behavioral health clinical information to Highmark Blue Shield, its Subcontractors and its Business Associates (together, "my health plan").

Section I: Physician Authorized to Release my Medical Information

Name		
Street Address		
City	State	Zip

Section II: Patient Information

I hereby voluntarily authorize physician(s) named in Section I possessing medical information to release this information to my health plan. This voluntary authorization includes, without limitation, the release of past, present or future: behavioral health clinical information that may also include, alcohol and drug abuse treatment, psychological/psychiatric testing and evaluation information, and other information regarding medical diagnosis, treatments and/or conditions for the purpose of _____.

Patient Name	Date of Birth (MM/DD/YYYY)
Subscriber Name	Contract Number/Member ID Number

Section III: Expiration

This voluntary authorization expires 12 months from the date of this release unless otherwise indicated or revoked earlier.

This authorization will expire: _____/_____/_____
Month Day Year

OR

The date patient's Highmark Blue Shield health coverage ends: _____/_____/_____
Month Day Year

Section IV: Copy of Authorization

Please keep a copy of your signed voluntary authorization. A photocopy is as valid as the original.

Section V: Right to Withdraw Authorization

I understand the nature of this authorization and that I may withdraw this voluntary authorization at any time by giving written notice to the office listed on page 1. I further understand that withdrawal of this voluntary authorization will not affect any action taken by my health plan in reliance on this voluntary authorization prior to receiving my written notice of withdrawal.

Section VI: Signature

Patient's Signature: _____ Date: _____

If a legal representative signs this voluntary authorization form on behalf of the patient, please complete the following:

Legal Representative's Name: _____Relationship to the Patient: _____
(please print)

Legal Representative's Signature: _____ Date: _____

(Continued on reverse)

Section VII: Witness Signature

To be completed if the patient is physically unable to provide a signature, but has indicated, verbally or behaviorally, that he/she consents to this release.

We affirm that _____ was physically unable to provide a signature, understands the nature of this consent, and freely gave his/her verbal or behavioral consent. This authorization shall remain in effect from this date to _____ (12 months hence). However, this may be revoked by verbal or behavioral communication to the treating physician.

Witness Signature: _____ Date: _____