



**AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION**

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

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, substance abuse records, or HIV testing 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.

Check if this authorization is to include HIV testing records.

SECTION B: Individual authorizing use and/or disclosure.

Patient's Name: _____

Address: _____

Telephone: _____

Date of Birth: ____/____/____

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

Approved by Legal: _____

Date: _____

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:

If this authorization is for use and/or disclosure of protected health information for pre-enrollment underwriting or risk-rating or determination of eligibility for enrollment in or benefits under a health plan, then the authorization shall include and apply to any and all protected health information related to treatments where you have requested a restriction and/or for any health care item or service for which the health care provider has been paid out of pocket in full.

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 Highmark Blue Cross and Blue Shield West Virginia (HIGHMARK WV) 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.

HIGHMARK WV Privacy Office
Address: P.O. Box 1948 Parkersburg, WV 26102
Telephone: (304) 424-9026 Fax: (304) 424-0322

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 HIGHMARK WV's 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.

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

Please send completed form to:
HIGHMARK WV Legal Department
Address: P.O. Box 1948 Parkersburg, WV 26102
Telephone: (304) 424-7700 Fax: (304) 424-9875