How to Authorize the Release of Psychotherapy Notes FEP

Instructions

Fill out this form to let us share notes that a mental health provider made during counseling or therapy sessions. The provider keeps these notes as a record of treatment and progress. Without this release, we would not share these notes, in most cases.

Note: You may have to call the mental health provider to get copies of psychotherapy notes. We do not usually get or keep copies of them.

Make sure to tell us:

- Whom you want to receive a copy of the psychotherapy notes
- How these notes are to be used

If you have questions about this form, please call Customer Service at the number listed on the back of your Member ID card.

Notice of Privacy Practices

Our Notice of Privacy Practices describes how we may use and disclose member personal information and members' rights concerning it. This notice is on our website at *www.premera.com*. If you need a paper copy, call Customer Service at the number listed on the back of your Member ID card.

Questions? Call Customer Service:

FEHB: 800-562-1011 (TTY: 711)
PSHB: 800-550-1722 (TTY: 711)

BlueCross BlueShield
Federal Employee Program

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- Please fill out all the information below.
- **Please print clearly**.
- Make a copy for your records and send the completed form in one of three ways:
  1. Secure Messaging through your MyBlue account at fepblue.org
  2. Fax: 877-202-3149
  3. Mail: FEP Appeals, PO Box 91058, Seattle, WA 98111-9158

Please note: We will mail your copies within **30** days of getting this form, unless we notify you in writing within those 30 days that we need 30 more days and why. We will also let you know if we need to charge a fee for any copies.

A. Member information

Member's name: first name, middle initial, last name	Member's date of birth (mm/dd/yyyy)
Subscriber's name: first name, middle initial, last name	Subscriber ID number

B. Your information if you are not the member

Important: If you are not the member, you must be the member's parent, legal guardian, or holder of the power of attorney (POA). If you are the legal guardian or holder of POA, please send legal proof with this form.
Your name: first name, middle initial, last name
I am not the member. I am the (select one): ❍ Legal guardian ❍ Parent ❍ Holder of Power of Attorney/Legal Representative (must attach supporting legal documentation)

C. Mailing address – Tell us to whom and where you want us to release psychotherapy notes for this member.

Send to - select one ❍ Member ❍ Parent, legal guardian, or holder of the POA ❍ Another person			
Full name: first name, middle initial, last name			
Mailing address	City	State	ZIP code
Daytime phone – include area code			

D. Type of information you are requesting

Reason for release - select one.

❍ At the member's request

❍ Other. Please state the specific date, time period and event or condition. Example: "a research study"

Date(s) of the record(s) - This could be a range of dates or multiple dates.

E. Signature – Print this form then sign it below.

Who must sign this form

- For a member aged 12 or younger, the parent or legal guardian can sign.
- For a member aged 13 or older, the member must sign, unless a court with jurisdiction has deemed the member incapable of consenting to his or her own services and has appointed a legal guardian.

By signing my name, below, I understand and agree to the following:

AUTHORIZING THE RELEASE: I allow Premera Blue Cross and its affiliates (the "Company") to release psychotherapy notes only to the person or organization that I listed, above. I understand that the Company needs my written authorization to release these records.

CANCELLING THIS AUTHORIZATION: I may change my mind and cancel this release at any time by writing the Company. After the Company gets my written notice, the Company will cancel this release within five (5) business days. During these five days, the Company may have shared some or all my information. The Company is not liable for this information.

SHARING THIS INFORMATION: The person or organization that receives these notes may be able to share them. State and federal privacy rules may no longer protect them.

DURATION OF RELEASE: This release lasts for twenty-four (24) months from the signature date, below, or as stated, above, under "Reason for Release," unless I write to cancel it.

RIGHT OF REFUSAL: I have the right NOT to sign this authorization. My refusal to sign this form will not affect the member's enrollment in a health plan or eligibility for health benefits.

Sign your name	Printed name
X_____	Date signed (mm/dd/yyyy)