

HIP* AUTHORIZATION TO USE AND DISCLOSE PSYCHOTHERAPY NOTES

Federal regulation defines psychotherapy notes as notes that are recorded in any medium by a mental health professional documenting or analyzing the contents of conversation during a counseling session, and that are separated from the rest of the individual's medical records. Psychotherapy notes do not include medical prescriptions, counseling session start and stop times, modalities and frequencies of treatment rendered, results of clinical tests, or summaries of diagnosis, functional status, treatment plans, symptoms, prognosis or progress. After completing this form, please mail it to: HIP Health Plan of New York, Outbound Call Unit, Customer Service, 2nd Floor, 55 Water Street, New York, NY 10041-8190. It may also be faxed to 1-646-447-3069.

Member's Name: _____

Health Plan ID #: _____

Home Address: _____

Home Telephone: _____

Date of Birth: _____

I authorize HIP to disclose my protected health information as follows:

NOTES TO BE DISCLOSED

Include genetic information.

RECIPIENT OF INFORMATION

Name: _____

Address: _____

REASON FOR DISCLOSURE

At my request.

- or -

For the following purposes: _____

TERM OF AUTHORIZATION

Authorization will remain in effect until the _____ day of _____, 200__.

- or -

Authorization will remain in effect until I revoke it in writing, but for no longer than six (6) years from the initial date of authorization.

CONDITIONS OF AUTHORIZATION

I understand that:

- ✓ I may refuse to sign this authorization.
- ✓ I will receive a signed copy of the authorization.
- ✓ The information released to a third party pursuant to the authorization may no longer be covered by state and federal privacy laws.
- ✓ I have the right to revoke the authorization at any time, and that the revocation must be in writing and sent to HIP Health Plan of New York, Compliance Department, 13th Floor, 55 Water Street, New York, NY 10041-8190. It may also be faxed to 1-646-447-3217.
- ✓ The revocation will be effective immediately upon HIP's receipt of my written notice, except that the revocation will not affect any action taken by HIP in reliance on the authorization prior to receipt of my written notice of revocation.
- ✓ The authorization will be maintained by HIP for a period of six (6) years or as prescribed by law.
- ✓ HIP will not condition my enrollment or eligibility for health insurance benefits on my provision of the authorization, unless it requested the authorization before my enrollment solely for eligibility or enrollment determinations relating to me.
- ✓ HIP may not condition payment of a claim for specified health insurance benefits on my provision of the authorization.

I have read and understood the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize HIP to use or disclose my health information in the manner described above.

Signature of Member Date

If the member is a minor or otherwise unable to sign this authorization, the following is required:

Signature of Personal Representative Date

DESCRIPTION OF AUTHORITY

Parent Legal Guardian** Power of Attorney**

*HIP includes the Health Insurance Plan of Greater New York and HIP Insurance Company of New York.

**Documentation is required to demonstrate Legal Guardianship or Power of Attorney.