

# HIP HEALTH PLANS\* 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.

Member's Name: \_\_\_\_\_

HIP ID #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

## NOTES TO BE DISCLOSED

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Include genetic information.

## RECIPIENT OF NOTES

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 24 months 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 Plans' HIPAA Privacy Officer: Valerie Reardon, SVP, Corporate Compliance and Internal Audit, 7 West 34<sup>th</sup> Street, New York, New York 10001.
- ✓ The revocation will be effective immediately upon HIP Health Plans' receipt of my written notice, except that the revocation will not affect any action taken by HIP Health Plans in reliance on the authorization prior to receipt of my written notice of revocation.
- ✓ The authorization will be maintained by HIP Health Plans for a period of six (6) years or as prescribed by law.
- ✓ HIP Health Plans 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 Health Plans 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 Health Plans to use or disclose my health information in the manner described above.

\_\_\_\_\_  
Signature of Member

\_\_\_\_\_  
Date

If 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 Health Plans is comprised of 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.