EBPA

AUTHORIZATION TO RELEASE INFORMATION

SECTION A: The Individual (or the Individual's Personal Representative) confirming the authorization.

I authorize the use and/or disclosure of my protected health information as described in Section C below. I understand this authorization is voluntary and made to confirm my direction.

I understand that, if the persons or organizations I authorize in Section C below to receive and/or use the protected health information described below are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose my protected health information and it may no longer be protected by federal health information privacy laws.

Member/Patient Name: _____ Date of Birth: _____

Participant ID Number: _____ Telephone: _____

Address: _____

SECTION B: Psychotherapy Notes.

☐ Check if this authorization is for psychotherapy notes. Psychotherapy notes are notes recorded, in any medium, by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.

IF THIS AUTHORIZATION IS FOR PSYCHOTHERAPY NOTES, YOU MUST *NOT* USE IT AS AN AUTHORIZATION FOR ANY OTHER TYPE OF PROTECTED HEALTH INFORMATION.

SECTION C: The use and/or disclosure being authorized.

Protected Health Information to Be Use and/or Disclosed (if this authorization is for psychotherapy notes (see Section B), no other type of protected health information may be listed on this authorization):

Information related to:

- ❑ General health care (excluding the items listed below)
- ❑ Alcohol and/or Chemical Dependency
- ❑ Reproductive Health (including abortion, pregnancy, contraception, and fertility treatments)
- ❑ Sexually Transmitted Diseases (including HIV/AIDS)
- ❑ Mental Health/Psychiatric Disorders
- ❑ Other (Please be specific. You may designate by date of service, name of provider, a specific diagnosis, etc.):

_____

_____

_____

Entities Authorized to Use or Disclose: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including EBPA, LLC, who you are authorizing to make use of and/or to disclose the protected health information described above

_____ _____

_____ _____

_____ _____

Entities Authorized to Receive and Use Protected Health Information: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing our Company to disclose and/or let use the protected health information described above. Please provide address and telephone number if known:

_____ _____

_____ _____

_____ _____

Specific Purpose For Release and How Protected Health Information Will Be Used**:**

_____

_____

_____

SECTION D: Expiration and Revocation.

Expiration: This authorization will expire (complete one):

☐ On ____/____/_____

☐ On occurrence of the following event (If related to an event, such event must relate to the individual or to the purpose of the use and/or disclosure being authorized. For example, you might choose to have this authorization terminate when your coverage terminates.):

_____

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the HIPAA Officer at EBPA, LLC., 46 Bowdoin Street, S. Burlington, VT 05403. I understand that my revocation will be effective when EBPA, LLC. receives it and that my revocation of this authorization will *not* affect any action EBPA, LLC. took in reliance on this authorization before receiving my written notice of revocation.

SECTION E: Conditioning.

Payment, treatment, enrollment or eligibility for benefits may not be conditioned on the signing of this authorization unless this authorization is for the purposes of the following:

1. Research-related treatment
2. Determinations relating to underwriting or risk taking prior to enrollment in the health plan
3. Creating protected health information solely for disclosure to a third party

SECTION F: Signature.

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to EBPA, LLC. I understand that, by signing this form, I am confirming my authorization that EBPA, LLC. may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual/Authority to act as Personal Representative of Individual: _____

_____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT

Return form to: HIPAA/Privacy Officer, PO Box 2365 So. Burlington, VT 05407-2365, fax # 802-846-2728