AUTHORIZATION TO REQUEST, USE OR RELEASE PSYCHOTHERAPY NOTES

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED

PART A: INFORMATION of HMSA MEMBER who is authorizing the request or release

Last Name	First Name		MI
Address	City	State	ZIP Code
Email	Home Phone # ( )	Cell Phone # ( )	
HMSA Subscriber Number(s) (Located on your membership card)		Birth Date _ _ /_ _/_ _ _ _	

PART B: REQUEST TYPE (Choose only one request per form)

- ◯ **Request Notes** – This allows HMSA to obtain psychotherapy notes from the person or organization indicated in Part C of this form.
- ◯ **Release Notes** – This allows HMSA to send copies of psychotherapy notes to a person or organization you indicate in Part C of this form.
- ◯ **Revoke an Existing Authorization to Request Notes** – Checking this box indicates your request to terminate a previously approved authorization to request psychotherapy notes from the person or organization you indicate in part C of this form.
- ◯ **Revoke an Existing Authorization to Release Notes** – Checking this box indicates your request to terminate a previously approved authorization to release psychotherapy notes to the person or organization you indicate in part C of this form. Enter an effective date for the termination: _ _ /_ _ /_ _ _ _.

PART C: PERSON OR ORGANIZATION HMSA IS AUTHORIZED TO REQUEST/RELEASE TO (All data fields must be completed)

Last Name	First Name		MI
Address	City	State	ZIP Code
Organization Name	Telephone # ( )	Fax # ( )	

PART D: APPOINTMENT PURPOSE AND EXPIRATION (All data fields must be completed)

I hereby authorize the request and/or release of my psychotherapy notes for the following purpose (specifically and meaningfully describe the purpose for this authorization and the psychotherapy notes that this authorization will allow to be requested, used, and/or disclosed):

(Continued on next page)

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Expiration	This authorization will expire one year from the date on which it was signed or as specified below: ☐ Until: _ _ /_ _ /_ _ _ _ (must be less than one year) ☐ Event described here: _____ (must occur within one year)

PART E: YOUR INDIVIDUAL RIGHTS

I understand that (**please read**):

- I have the right to authorize that the protected health information held by HMSA be released or received by HMSA to or from the persons or organizations I've identified in Part C above. The person or organization I've identified may not be subject to federal health information privacy laws. If this is the case, they may further release my confidential member information and federal health information laws may no longer protect it.
- This authorization is voluntary. HMSA will not condition your enrollment in a health plan or eligibility for benefits on receiving this authorization.
- I may revoke this authorization at any time by giving HMSA five business days written notice to the address indicated below. Cancellation of this authorization will not affect any action HMSA took prior to receiving my written notification.
- I may request a copy of this signed form.
- If I have questions about this form, I may contact HMSA at (808) 948-6111 on Oahu.

PART F: SIGNATURE

I, (print member's name) _____ , had full opportunity to read and consider the contents of this authorization. **I understand that, by signing this form, I am authorizing the use, request, and/or release of my protected health information, as described in this form.**

Member/Authorized Signature: _____ **Date:** _ _ /_ _ /_ _ _ _

If signed by other than the member or parent of minor child, please print your name below and indicate your relationship. Provide a copy of verification of your legal right (e.g., power of attorney documentation) to make this authorization.

Authorized Representative Name: _____

Relationship to Member: _____

INCOMPLETE FORMS WILL NOT BE PROCESSED
ALL FIELDS ARE REQUIRED UNLESS OTHERWISE SPECIFIED

Please complete, sign, and submit this form to:
HMSA Privacy Office, P.O. Box 860, Honolulu, HI 96808-0860, (fax) 952-7580

(00) 0135-5660 6:16 LE