Patient's Full Name: _____ **Date of Birth:** _____

Social Security Number: _____ **Medical Record No:** _____

RELEASE OF GENERAL HEALTH RECORDS

I AUTHORIZE PRESBYTERIAN HEALTH PLAN, INC. OR PRESBYTERIAN INSURANCE COMPANY, INC. ("PRESBYTERIAN") TO USE OR RELEASE (DISCLOSE) THE FOLLOWING HEALTH RECORDS OF THE ABOVE NAMED MEMBER ("MEMBER").

☐ Billing Records ☐ Case Management Records ☐ All Health Records
☐ Other (Please specify)_____

From (circle one): PHP PIC

For date(s) of service from: _____ to _____

To (Name): _____

Address: _____ City: _____

State: _____ Zipcode: _____ Telephone Number: _____ Facsimile (FAX) Number: _____

Records released for the following purpose(s):

☐ At the request of the Individual
☐ To determine eligibility for enrollment in Presbyterian's health plan(s) **(If checked authorization does NOT include psychotherapy notes)**
☐ For Marketing (specify campaign): _____
☐ If checked, Presbyterian will receive direct or indirect payment from a third party as a result of this activity.
☐ Other (Describe each purpose of the requested use or disclosure)
_____

IN ADDITION TO RELEASE OF THE GENERAL HEALTH RECORDS INDICATED ABOVE, BY INITIALING BELOW I ALSO AUTHORIZE THE RELEASE OF HEALTH RECORDS PERTAINING TO THE FOLLOWING CONDITIONS.

(Initial ONLY those records to be released):

_____ Psychotherapy Notes
If initialed, this authorization may NOT authorize the release of any health records other than Psychotherapy Notes. To release other health records a separate authorization is required.

_____ Health Records Related to Emotional/Mental Health/Developmental Disabilities/Psychiatric Conditions ***(Excludes Psychotherapy Notes)***

_____ Health Records Related to Drug/Alcohol/Substance Abuse

_____ Health Records Related to Sexually Transmitted Diseases

_____ Health Records Related to Human Immune Deficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)

EXPIRATION: I understand that I may cancel this authorization at any time by sending Presbyterian my notice of cancellation in writing. I understand that Presbyterian may have already used or released records according to this authorization prior to receiving my notice of cancellation. I understand that if this authorization is cancelled, an insurer may still have the legal right to contest a claim or the insurance policy. The insurer's right only applies if this authorization is requested as a condition of obtaining insurance coverage.

UNLESS CANCELLED, THIS AUTHORIZATION EXPIRES (either Event OR Date is required):

☐ In 6 months ☐ When Event occurs (specify): _____
OR on Date: _____

I UNDERSTAND THAT THIS AUTHORIZATION TO RELEASE HEALTH RECORDS IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. I understand signing this authorization may be required as a condition of my enrollment in a Presbyterian health plan if Presbyterian has requested this authorization prior to enrollment in order to determine eligibility or for its underwriting or risk rating determinations. If this authorization is a condition of enrollment in a health plan it does NOT include permission to release psychotherapy notes.

I have read and understand this authorization form including statements that appear on the reverse side of this page. I am the Member or I am legally authorized as the Member's representative to execute this authorization and accept these terms.

_____ _____ _____
Member or Authorized Representative/Relationship to Member Date Time
(Relationship to Member required if signed by Representative)

PRESBYTERIAN