

Complete the following form only if applicable:



**AUTHORIZATION FOR RELEASE OF DRUG OR ALCOHOL ABUSE RECORDS
AND PSYCHOTHERAPY NOTES**

I have requested an external review pursuant to Idaho Code Section 41-5906. In order to obtain that review, I understand that I must sign below to authorize Regence BlueShield of Idaho, whose decision is the subject of this request, and its subcontractors and all applicable medical providers, to release all information relating to the decision to be reviewed including, but not limited to, my files and medical record information, which may include mental health information to the Idaho Department of Insurance (DOI). I authorize the DOI to provide or to instruct Regence BlueShield of Idaho and/or its subcontractors and providers to provide such information to the independent review organization (IRO) assigned by the DOI to perform the external review. I acknowledge that information to be used or disclosed as a result of this authorization may include records that are protected by federal and/or state laws applicable to substance abuse and psychotherapy. I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO PSYCHOTHERAPY, DRUG AND/OR ALCOHOL ABUSE. The recipient of drug and/or alcohol abuse and psychotherapy information disclosed as a result of this authorization will need my further written authorization to re-disclose this information.

I, _____, hereby reaffirm my request for an external review. I attest that the information provided in this request is true and accurate to the best of my knowledge. I authorize Regence BlueShield of Idaho, its subcontractors and agents, and my health care providers to release all relevant medical or treatment records to the independent review organization (IRO) and the Idaho Department of Insurance (DOI). I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO PSYCHOTHERAPY, DRUG AND/OR ALCOHOL ABUSE. I understand the IRO will use this information to make a determination on my external review and the information will be kept confidential and not be released to anyone else. This release is valid for one year unless it expires sooner upon the IRO rendering a final decision or upon revocation. I understand that the decision of the IRO may be binding and that neither the DOI nor the IRO may authorize services in excess of those covered by my health plan.

I acknowledge that I may revoke this authorization at any time. My revocation will be effective upon receipt, but will not affect actions already taken on the basis of the authorization. In any event, this authorization expires upon the IRO rendering a final decision regarding this external review.

I understand completing this authorization is not a condition to receive treatment, payment or eligibility. Regence BlueShield of Idaho is not responsible for any action taken by an authorized

recipient of my protected health information. I am aware that an authorized recipient may redisclose my information and the privacy protections provided by law may be lost.

Signature of Covered Person (or authorized representative)*

Date

*(Parent, Guardian, Conservator or Other – Please Specify)

Printed Name of Authorized Representative

*Parent (if patient is under 18 years old), guardian (if other than patient), conservator, attorney or other. If other than parent of minor, attach a written authorization to represent patient.

Return to:

**Idaho Dept of Insurance
PO Box 83720
Boise, ID 83720-0043**