Liberty Mutual. INSURANCE

Authorization to Obtain and Release Psychotherapy Notes

EMPLOYEE NAME _____ CLAIM NO: _____

EMPLOYER/SPONSOR/CUSTOMER NAME _____

Return to: _____

I **authorize** any physician, health plan, health care professional, mental health professional, hospital, clinic, medical facility, other health care providers, government agency and any insurance or reinsurance company to release any psychotherapy notes relating to me to the particular Company in the Liberty Mutual Group of companies to which I am submitting a claim, or to its agents, employees, or representatives, or to the Plan Sponsor (if Self Insured Plan), or to persons or other organizations providing claims management services.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health plan, health care professional, hospital, clinic, medical facility, other health care provider, government agency, and any insurance or reinsurance company to release and disclose all of my psychotherapy notes without restriction, including psychotherapy notes recorded in any medium documenting or analyzing the contents of conversations(s) during private counseling sessions and/or group, joint or family counseling sessions.

I **understand** the Company or Plan Sponsor will use the information obtained under this Authorization or directly from me to determine eligibility for insurance benefits, which may include assessing ongoing treatment. Any information obtained will not be released to any person or organizations EXCEPT to the Plan Sponsor, reinsuring companies, other companies in the Liberty Mutual Group of companies to which I am submitting a claim, Employee Assistance Programs (EAP) or other disease management or assistance programs providing services to the Plan Sponsor and/or to the Company, persons or other organizations providing claims management and claim advisory services to the Plan Sponsor and/or to the Company, the Group Policyholder and its agents/vendors for purposes of auditing the Company's administration of claims under the policy and/or assessing statistical claim data related to its benefit programs, persons or organizations providing medical treatment or services in connection with my claim, or any person performing business or legal services for them in connection with my claim(s) or as may be otherwise permitted or required by law. I also understand that, to the extent reasonably necessary, information obtained may be released to other insurance companies or insurance support organizations to detect or prevent criminal activity, fraud, material misrepresentation, or material non-disclosure in connection with insurance transactions.

I **understand** that the Company must comply with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this Authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law.

I **understand** that this Authorization is valid for two years from the date appearing below with my signature. I understand that I have a right to request and receive a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. I understand that I have the right to revoke this Authorization at any time by written notification to the Plan Sponsor and/or the Company in the Liberty Mutual Group of companies for which I submit a claim. I understand that revocation will not apply to any information that is requested prior to Liberty receiving notice of revocation.

I **understand** that if I refuse to sign this Authorization to release all of my psychotherapy notes or if I alter or revoke it, the Company may not be able to process my claim for benefits and may not be able to make benefit payments.

_____ _____

Claimant Name (Print) Date of Birth

_____ _____

Claimant Signature Date

_____

Claim Number: