



Authorization to Disclose Protected Health Information

Section A - Individual whose Protected Health Information (PHI) will be disclosed.

Full Name: _____

Group #: _____ Identification#: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____ Telephone Number: () _____

Email address (optional): _____

Section B – I authorize the person(s) listed below to inquire/receive information about the following:

(check all that apply) Application/enrollment information Benefit/Claims information

General policy information Premium information

Other (Please specify) _____

Information will be provided by employees of Blue Cross and Blue Shield of Illinois.

1) Full Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____ Telephone Number: () _____

2) Full Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____ Telephone Number: () _____

Section C - I understand by completing this form I agree to the following:

- This authorization is voluntary.
- This authorization will expire on the date indicated here _____. I understand I may revoke this authorization at any time by written notification to Blue Cross and Blue Shield of Illinois but if I do revoke this authorization, it will not have any affect on any action Blue Cross and Blue Shield of Illinois took before they received the revocation.
- Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this form.
- Information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving the information
- I should retain one duplicate authorization form as my copy.

Section D - This Authorization is at my request.

Signature of Individual named in Section A _____
Today's Date

Section E – If this Authorization is at the request of a Personal Representative, please complete the information below. (Attach copies of supporting documentation, if necessary)

_____ Personal Representative's Name	_____ Personal Representative's Telephone #	_____ Relationship to Individual
_____ Personal Representative's Address	_____ City	_____ State
		_____ ZIP



Authorization to Disclose Protected Health Information

Instructions for completing this form

Under the HIPAA Privacy Rule, an individual may authorize release of his or her protected health information (PHI) to a specific person. Please follow the instructions below for completing this Authorization to Disclose Protected Health Information (PHI) Form. Please contact the Customer Service telephone number on the back of your identification card if you have questions about completing this form.

Please Remember:

- One authorization form can be used for a range of and/or multiple services or providers.
- Authorization forms can be completed claim by claim, procedure by procedure, or for a range of services within specified timeframes.
- The individual's use of an Authorization Form is always totally voluntary.

Section A: Include information identifying the individual whose PHI will be disclosed.

Section B: Information identifying the person(s) authorized to receive the individual's PHI. For example, the individual could authorize disclosure of his or her PHI to a close friend, a broker, an attorney, or a specific member of his or her employer's benefits staff.

The individual may also authorize disclosure of his or her PHI to an organization. Include information identifying the organization's job titles authorized to PHI (e.g., Benefits Representatives, Human Resources Department, ABC Company; or Client Representatives, XYZ Insurance Agency, etc).

Be sure to check the appropriate boxes to indicate the type of information you are authorizing us to share with the person(s) named in this section.

Section C: Please include an expiration date in the space provided and read carefully before signing the authorization.

Section D: Include the signature of the individual whose PHI will be disclosed. If the individual is a minor dependent under age 18, a parent or guardian may sign the authorization. The Individual's Personal Representative may sign if the individual is not able to so do. (A Personal Representative has received legal authority to represent the individual)

Section E: If the individual's Personal Representative has signed Section D, the Personal Representative must also complete this section and provide legal documentation supporting legal authority.

Other Information:

If a brokerage agency is listed on the authorization, the proper job titles allowed to request PHI should be identified (e.g. broker, administrative assistant, etc. in XYZ Insurance Agency). The insured can include a range of dates and multiple providers on one form. These forms can be used on per claim basis, per procedure or a range of services within certain timeframes.

- **Please mail this completed Authorization Form to the following address:
Blue Medicare Rx 1020 Discovery Road, No. 100 Egan, MN 55121**