BlueCross BlueShield of Texas

Dear Member:

We need your approval before we can give out your records to others.
Just fill out and sign this form.

We've been asked to release your records to a person or company. Before we can do this, we need you to fill out the form that is with this letter and send it back to the address on the form. This form will tell us who can receive your records.

The form will be good for one year from the date you sign it unless you ask for it to end sooner.

Please be sure to fill out the whole form. Keep a copy for your records. Please don't change the form or leave things out. If there are problems, or if we have questions, we'll send you a letter or call you.

Once we get your signed form, we will process it quickly. If you have any questions, please call the Customer Service number on the back of your member ID card.

Sincerely,

Blue Cross and Blue Shield of Texas

Enclosure: Blue Cross and Blue Shield of Texas Member Authorization Form

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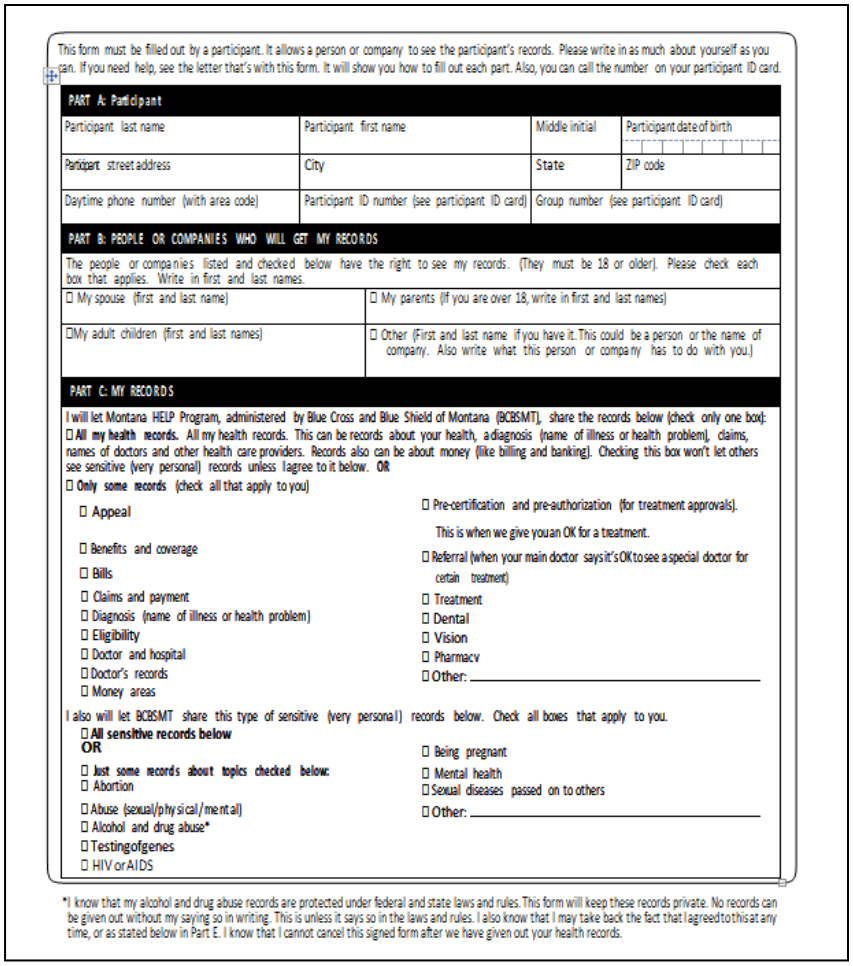
Blue Cross and Blue Shield of Texas Member Authorization Form Instructions
Please read the following for help completing page one of the form.

PART A: Member

- Print your last name, first name, and the first letter of your middle name.
- Write your date of birth like this: mm/dd/yyyy. For example, if you were born on October 5, 1960, you would write 10/05/1960.
- Write your full street address, city, state, and ZIP code.
- Write a daytime phone number (including area code) where you can be reached.
- ***Member ID number***
  - This number is on your member ID card.
- ***Group number***
  - This number is on your member ID card. If your ID card does not have a group number, leave this part blank.



This form must be filled out by a participant. It allows a person or company to see the participant's records. Please write in as much about yourself as you can. If you need help, see the letter that's with this form. It will show you how to fill out each part. Also, you can call the number on your participant ID card.

PART A: Participant

Participant last name	Participant first name	Middle initial	Participant date of birth
Participant street address	City	State	ZIP code
Daytime phone number (with area code)	Participant ID number (see participant ID card)	Group number (see participant ID card)	

PART B: PEOPLE OR COMPANIES WHO WILL GET MY RECORDS

The people or companies listed and checked below have the right to see my records. (They must be 18 or older). Please check each box that applies. Write in first and last names.

☐ My spouse (first and last name)	☐ My parents (If you are over 18, write in first and last names)
☐ My adult children (first and last names)	☐ Other (First and last name if you have it. This could be a person or the name of company. Also write what this person or company has to do with you.)

PART C: MY RECORDS

I will let Montana HELP Program, administered by Blue Cross and Blue Shield of Montana (BCBSMT), share the records below (check only one box):
☐ **All my health records.** All my health records. This can be records about your health, a diagnosis (name of illness or health problem), claims, names of doctors and other health care providers. Records also can be about money (like billing and banking). Checking this box won't let others see sensitive (very personal) records unless I agree to it below. **OR**
☐ **Only some records** (check all that apply to you)

☐ Appeal
☐ Benefits and coverage
☐ Bills
☐ Claims and payment
☐ Diagnosis (name of illness or health problem)
☐ Eligibility
☐ Doctor and hospital
☐ Doctor's records
☐ Money areas
☐ Pre-certification and pre-authorization (for treatment approvals). This is when we give you an OK for a treatment.
☐ Referral (when your main doctor says it's OK to see a special doctor for certain treatment)
☐ Treatment
☐ Dental
☐ Vision
☐ Pharmacy
☐ Other: _____

I also will let BCBSMT share this type of sensitive (very personal) records below. Check all boxes that apply to you.
☐ **All sensitive records below**
OR
☐ **Just some records about topics checked below:**
☐ Abortion
☐ Abuse (sexual/physical/mental)
☐ Alcohol and drug abuse*
☐ Testing of genes
☐ HIV or AIDS
☐ Being pregnant
☐ Mental health
☐ Sexual diseases passed on to others
☐ Other: _____

*I know that my alcohol and drug abuse records are protected under federal and state laws and rules. This form will keep these records private. No records can be given out without my saying so in writing. This is unless it says so in the laws and rules. I also know that I may take back the fact that I agreed to this at any time, or as stated below in Part E. I know that I cannot cancel this signed form after we have given out your health records.

PART B: People or companies who will get my records

- Check the box of the person or company who can see your records. Also, tell us the full name of the person or company to give your records to. Please do not use a general term like "my daughter" or "my son." You need to be very clear.
- If you check "Other," please give:
  - The first and last name (if you have it).
  - The company name (if this applies to you). And what they have to do with you.

PART C: My records

- Tell us what records you will let us give out: all or just some.
- To give out all of your records, check the first box.
- To give out only some records, check the second box.
- There is also a section about things that you think are very personal or very private to you. If you agree that we can give out these types of records, check the boxes that apply to you.

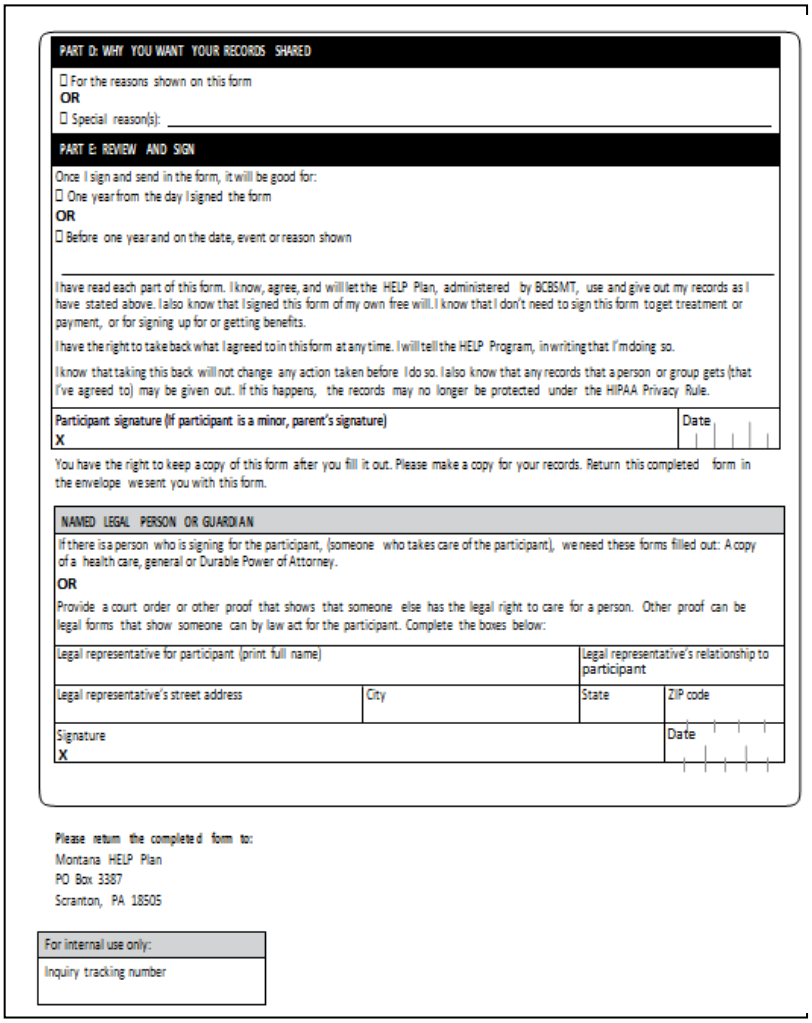
Please read the following for help completing page two of the form.

PART D: Why you want your records shared

- The first box tells us to give out your records as shown on this form.
- The second box tells us a special reason. This could be talking about a life insurance claim. This might be with a lawyer or family member. Write your reason in the space.

PART E: Review and sign

- Once you sign the form, it will be good for one of the following amounts of time:
  - Check the first box for one year. That's the normal time.
  - Check the second box to say the form you sign will be good for less than a year. Then give the date you want it to end.
- **Sign your name and put the date on the form.** Your name and signature ***must*** match what you wrote in PART A.
- You may be signing this form for someone else. If you have forms that say you have Power of Attorney for health care, or are a legal guardian or conservator, you must do this:
  - Fill in **Named Legal Person or Guardian**.
  - Give us a copy of the legal form that shows you have Power of Attorney. Put it in with this form.



PART D: WHY YOU WANT YOUR RECORDS SHARED

☐ For the reasons shown on this form
OR
☐ Special reason(s): _____

PART E: REVIEW AND SIGN

Once I sign and send in the form, it will be good for:
☐ One year from the day I signed the form
OR
☐ Before one year and on the date, event or reason shown

I have read each part of this form. I know, agree, and will let the HELP Plan, administered by BCBSMT, use and give out my records as I have stated above. I also know that I signed this form of my own free will. I know that I don't need to sign this form to get treatment or payment, or for signing up for or getting benefits.

I have the right to take back what I agreed to in this form at any time. I will tell the HELP Program, in writing that I'm doing so.

I know that taking this back will not change any action taken before I do so. I also know that any records that a person or group gets (that I've agreed to) may be given out. If this happens, the records may no longer be protected under the HIPAA Privacy Rule.

Participant signature (If participant is a minor, parent's signature) X	Date

You have the right to keep a copy of this form after you fill it out. Please make a copy for your records. Return this completed form in the envelope we sent you with this form.

NAMED LEGAL PERSON OR GUARDIAN

If there is a person who is signing for the participant, (someone who takes care of the participant), we need these forms filled out: A copy of a health care, general or Durable Power of Attorney.
OR
Provide a court order or other proof that shows that someone else has the legal right to care for a person. Other proof can be legal forms that show someone can by law act for the participant. Complete the boxes below:

Legal representative for participant (print full name)		Legal representative's relationship to participant	
Legal representative's street address	City	State	ZIP code
Signature X			Date

Please return the completed form to:
Montana HELP Plan
PO Box 3387
Scranton, PA 18505

For internal use only:
Inquiry tracking number

Here are samples of legal forms. These are used when a person needs someone else to make choices for them.

- **Health Care, General, or Durable Power of Attorney**. This form gives someone the legal power to act for you. This person can make health care choices for you. It might say this on the form: "to take charge of my person in the case of sickness of any kind." It may also say this "and in general to do and act for me and in my name all that I might do if I am not there."
- **Legal Guardianship**. This is when the court names someone to care for a person.
- **Conservatorship**. This happens when a judge names a person to be in charge. This would be when a person can't make choices for him or herself.
- **Executor of estate**. This type of form would be used when the person who is being spoken for has died.

Blue Cross and Blue Shield of Texas Member Authorization Form

This form must be filled out by a member. It allows a person or company to see the member's records. Please write in as much about yourself as you can. If you need help, see the letter that's with this form. It will show you how to fill out each part. Also, you can call the number on your Member ID card.

PART A: Member

Member's last name	Member's first name	Middle initial	Member's date of birth
Member'sstreet address	City	State	ZIP code
Daytime phone number (with area code)	Member ID number (see Member ID card)	Group number (see Member ID card)	

PART B: PEOPLE OR COMPANIES WHO WILL GET MY RECORDS

The people or companies listed and checked below have the right to see my records. (They must be 18 or older). Please check each box that applies. Write in first and last names.

☐ My spouse (first and last name)	☐ My parents (If you are over 18, write in first and last names)
☐My adult children (first and last names)	☐ Other (First and last name if you have it. This could be a person or the name of company. Also write what this person or company has to do with you.)

PART C: MY RECORDS

I will let XXXXXX XXXX Program, administered by Blue Cross and Blue Shield of Texas (BCBSTX), share the records below (check only one box):

☐ **All my health records.** All my health records. This can be records about your health, a diagnosis (name of illness or health problem), claims, names of doctors and other health care providers. Records also can be about money (like billing and banking). Checking this box won't let others see sensitive (very personal) records unless I agree to it below. **OR**

☐ **Only some records** (check all that apply to you)

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Bills
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or health problem)
- ☐ Eligibility
- ☐ Doctor and hospital
- ☐ Doctor's records
- ☐ Money areas
- ☐ Pre-certification and pre-authorization (for treatment approvals). This is when we give you an OK for a treatment.
- ☐ Referral (when your main doctor says it's OK to see a special doctor for certain treatment)
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other: _____

I also will let BCBSXX share this type of sensitive (very personal) records below. Check all boxes that apply to you.

☐ **All sensitive records below**
OR

☐ **Just some records about topics checked below:**

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol and drug abuse*
- ☐ Testing of genes
- ☐ HIV or AIDS
- ☐ Being pregnant
- ☐ Mental health
- ☐ Sexual diseases passed on to others
- ☐ Other: _____

*I know that my alcohol and drug abuse records are protected under federal and state laws and rules. This form will keep these records private. No records can be given out without my saying so in writing. This is unless it says so in the laws and rules. I also know that I may take back the fact that I agreed to this at any time, or as stated below in Part E. I know that I cannot cancel this signed form after we have given out your health records.

PART D: WHY YOU WANT YOUR RECORDS SHARED

☐ For the reasons shown on this form

OR

☐ Special reason(s): _____

PART E: REVIEW AND SIGN

Once I sign and send in the form, it will be good for:

☐ One year from the day I signed the form

OR

☐ Before one year and on the date, event or reason shown

_____

I have read each part of this form. I know, agree, and will let the HELP Plan, administered by BCBSXX, use and give out my records as I have stated above. I also know that I signed this form of my own free will. I know that I don't need to sign this form to get treatment or payment, or for signing up for or getting benefits.

I have the right to take back what I agreed to in this form at any time. I will tell the xxxxxx Program, in writing that I'm doing so.

I know that taking this back will not change any action taken before I do so. I also know that any records that a person or group gets (that I've agreed to) may be given out. If this happens, the records may no longer be protected under the HIPAA Privacy Rule.

Member signature (If member is a minor, parent's signature) **X**	Date

You have the right to keep a copy of this form after you fill it out. Please make a copy for your records. Return this completed form in the envelope we sent you with this form.

NAMED LEGAL PERSON OR GUARDIAN

If there is a person who is signing for the member, (someone who takes care of the member), we need these forms filled out: A copy of a health care, general or Durable Power of Attorney.

OR

Provide a court order or other proof that shows that someone else has the legal right to care for a person. Other proof can be legal forms that show someone can by law act for the member. Complete the boxes below:

Legal representative for member (print full name)		Legal representative's relationship to member	
Legal representative's street address	City	State	ZIP code
Signature **X**			Date

Please return the completed form to:
Blue Cross and Blue Shield of Texas
P.O. Box 805106
Chicago, IL 60680-4112

For internal use only:
Inquiry tracking number

To get auxiliary aids and services, or to get written or oral interpretation to understand the information given to you, including materials in alternative formats such as large print, braille or other languages, please call BCBSTX Customer Service on the back of your Member ID card.

Blue Cross and Blue Shield of Texas complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Texas does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Texas:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Texas has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-710-6984 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-710-6984 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-710-6984 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-710-6984 (TTY: 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-710-6984 (TTY: 711) 번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-710-6984 (رقم هاتف الصم والبكم: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-710-6984 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-710-6984 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-710-6984 (ATS: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-710-6984 (TTY: 711) पर कॉल करें।

هجوت: رگ ا هب ذ اب ز ي سراف وگ ت فگ ي م دي نک، ت لاي هـ ست ي ناب ز هـ ت روص ذ اگ يار ي ارب امش مهارف ي م د شاب. اب 1-855-710-6984 (TTY: 711) سامت دي ري گب.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-710-6984 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-710-6984 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-710-6984 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-710-6984（TTY: 711）まで、お電話にてご連絡ください。

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-710-6984 (TTY: 711).