



Standard Authorization to Use or Disclose Protected Health Information (PHI)

Unless instructed otherwise, return this form to: Blue Cross and Blue Shield of Texas, P.O. Box 660044, Dallas, TX 75266-0044

Section A: The individual for whom this authorization is being requested. Please complete the following:

Name _____		Group # _____	Identification\Subscriber # _____	
Social Security Number _____	Date of Birth _____			
Address _____	City _____	State _____	ZIP _____	
Area Code & Telephone Number _____	E-mail Address (if available) _____		Country _____	

Section B: Who will provide this information?

Name _____
Dept. _____
Address _____

Section C: Who will receive this information?

Name _____
Dept. _____
Address _____

Section D: Describe the specific Protected Health Information to use or disclose, including date(s):

This authorization will expire on: _____ (insert date or event).

Describe the reason for the release or request of information:

At the request of the individual.

Other: _____

Section E: I understand that:

- This authorization will expire on the date or event listed in Section D above.
- This authorization is voluntary.
- Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this form.
- I may revoke this authorization at any time by notifying in writing the company/individual listed in Section B from providing the PHI identified in this authorization, but if I do revoke this authorization, it won't have any affect on any actions Blue Cross and Blue Shield of Texas took before they received the revocation.
- 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 as my copy one of the duplicate authorization forms I received.

Section F: Signature.

I hereby authorize the use or disclosure of the Protected Health Information as described in Section D for the Individual listed in Section A.

Signature of Individual or Individual's Personal Representative Date: month/day/year

Section G: If Section F is signed by a Personal Representative, please complete the information below:

Personal Representative's Name _____		Relationship to Individual _____		
Personal Representative's Address _____	City _____	State _____	ZIP _____	
Personal Representative's Area Code & Telephone Number _____	Personal Representative's E-mail address (if available) _____		Country _____	