

To Complete Form go to Page 4

Use this form to authorize Blue Cross and Blue Shield of Texas (BCBSTX) to disclose your protected health information (PHI) to a specific person or entity. You may follow the instructions below or call the number listed on your Member ID card if you need help completing the form. You must complete the entire form.

Please note:

- One authorization form can be used for multiple services or providers or you can complete the form claim by claim, procedure by procedure, or for services provided during certain time periods.
- The use of the authorization form is voluntary.

Section I. Name and information of person whose PHI is being disclosed

Jane Doe 05-10-1962
Name Date of Birth

123456 XOP123456789 ### - ## - ####
Group Number Identification/Subscriber Number Social Security Number

123 Main Street Anytown
Address City

TX 12345 555-555-5555
State Zip Code Area Code & Phone Number

The information in Section I applies to the person whose PHI is being disclosed. The person could be the policy holder, his or her spouse, a dependent or any other person covered under the policy or a person who has their own coverage. In this example, Jane Doe is the person making the request.

Section II. Authorization and Purpose

I authorize BCBSTX to release my PHI to the person or organization listed below. I understand if the person or organization listed below is not a health plan or health care provider, the PHI may not be protected by federal privacy laws.

Suzy Smith Daughter
Persons/Organizations authorized to receive your information Relationship

Assisting in medical care
Purpose

123 Main Street Anytown TX 12345
Address City State Zip Code

The information in Section II identifies the person or organization that will be receiving the PHI about the person named in Section I. A person that needs access to the PHI could be a family member, a close friend, a broker, or an attorney. If the person wants PHI to go to an organization, please include the area and/or job title of the person at the organization, for example, Benefits Representatives, Human Resources Department, Associate XYZ Insurance Agency, etc. In this example, Jane Doe is authorizing the release of PHI to her daughter Suzy Smith.

Section III. Description of Sensitive Protected Health Information (SPHI) and PHI to be Released

Complete Parts A and B of this section

A. Release of SPHI that may be protected under State Law. **If you check “yes,” you are** authorizing BCBSTX to release the SPHI listed below and if applicable to your data release request, it will be included in the information you select in III.B. **If you check “no” or make no selection at all**, SPHI will not be released. This authorization may not be used for the release of Psychotherapy Notes.

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome,
- **Sexually transmitted or “communicable” diseases (includes hepatitis, as well as venereal diseases),**
- Drug, alcohol or substance abuse,
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions), and
- Genetic testing.

Yes

No

The information in Section III-A applies when a person wants specific SPHI as listed above to be released to their authorized representative, the person must specifically authorize that release. In this example, Jane has agreed to let her daughter Suzy Smith receive her SPHI.

B. Description of PHI to be released. You may select one or more

		<u>Dates of Services</u>	
		From:	To:
<input type="checkbox"/>	Health Plan Benefit Information: Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).	_____	_____
<input checked="" type="checkbox"/>	Claims Information: Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.).	06-12-15	04-30-18
<input type="checkbox"/>	Service Determination Information: Includes any information related to pre-service, concurrent and post-service decisions.	_____	_____
<input type="checkbox"/>	Premium Information: Includes information related to billing cycles, bank draft changes, etc.	_____	_____
Provider/Supplier Name: _____			
<input type="checkbox"/>	Services from Provider or Supplier: Describe the exact information you want released: _____	_____	_____
<input type="checkbox"/>	Other: Add other information that is not listed above. _____	_____	_____

Section III-B is where the person specifies what PHI they are authorizing BCBSTX to release. In this example, Jane is authorizing BCBSTX to release claims information from 6-12-15 to 4-30-18 to her daughter Suzy Smith.

Section IV. Expiration & Right to Revoke or Terminate the Authorization

Expiration: Select a date/event when authorization will expire. The authorization cannot be processed if this is left blank.

One year from the date it is signed Other (insert date or event): _____

Right to Revoke/Terminate: You may end this authorization at any time by giving written notice to BCBSTX at the address listed below; however, BCBSTX is not responsible for the PHI released before the authorization was terminated.

In Section IV, the person must select a date when this authorization will end. All valid authorizations must contain a specific expiration date or event; for example: "hospitalization end date", "rehabilitation end date", etc. In addition, BCBSTX is providing information about the right to terminate an authorization at any time. In this example, the authorization remains valid for one year from the date it was signed unless Jane revokes it.

Section V. Signature & Acceptance of Terms.

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization.

Jane Doe Signature Self Relationship 4-30-18 Date (MM-DD-YY)

Document must be signed by the person, the parent of a minor child or the **person's authorized** representative. If you are a parent signing on behalf of a minor child, please sign your name – **not the child's** name. This authorization will expire when the minor child turns 18 years of age, unless proof of legal guardianship is produced. If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and provide copies of the appropriate Legal documents. If these documents are already on file with BCBSTX, you do not need to provide.

Authorized Representative's Name Relationship to Person

Authorized Representative's Address City

State Zip Code _____
Authorized Representative's Area Code & Phone Number

In Section V, the person identified in Section I signs the form unless the person identified in Section I is a minor under the age of 18 – then the parent or guardian signs the form. In this example, Jane is signing on her own behalf. However, if Jane was a minor, her parent or guardian would sign their name on the form.

Before sending this form, make a copy for your records:

- Photocopy this signed authorization, or
- Complete and sign the duplicate form you received or printed

*The rest of the form contains instructions for submitting the form to BCBSTX.
Please keep a signed copy for your records.*

Use this form to authorize Blue Cross and Blue Shield of Texas (BCBSTX) to disclose your protected health information (PHI) to a specific person or entity. You may follow the instructions below or call the number listed on your Member ID card if you need help completing the form. You must complete the entire form.

Please note:

- One authorization form can be used for multiple services or providers or you can complete the form claim by claim, procedure by procedure, or for services provided during certain time periods.
- The use of the authorization form is voluntary.

Section I. Name and information of person whose PHI is being disclosed

Name		Date of Birth	
Group Number	Identification/Subscriber Number	Social Security Number	
Address		City	
State	Zip Code	Area Code & Phone Number	

The information in Section I applies to the person whose PHI is being disclosed. The person could be the policy holder, his or her spouse, a dependent or any other person covered under the policy or a person who has their own coverage.

Section II. Authorization and Purpose

I authorize BCBSTX to release my PHI to the person or organization listed below. I understand if the person or organization listed below is not a health plan or health care provider, the PHI may not be protected by federal privacy laws.

Persons/Organizations authorized to receive your information		Relationship	
Purpose			
Address		City	State Zip Code

The information in Section II identifies the person or organization that will be receiving the PHI about the person named in Section I. A person that needs access to the PHI could be a family member, a close friend, a broker, or an attorney. If the person wants PHI to go to an organization, please include the area and/or job title of the person at the organization, for example, Benefits Representatives, Human Resources Department, Associate XYZ Insurance Agency, etc.

Section III. Description of Sensitive Protected Health Information (SPHI) and PHI to be Released

Complete Parts A and B of this section

A. Release of SPHI that may be protected under State Law. **If you check “yes,” you are authorizing BCBSTX to release the SPHI listed below and if applicable to your data release request, it will be included in the information you select in III.B. If you check “no” or make no selection at all, SPHI will not be released. This authorization may not be used for the release of Psychotherapy Notes.**

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome,
- Sexually **transmitted or “communicable” diseases (includes hepatitis, as well as venereal diseases),**
- Drug, alcohol or substance abuse,
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions), and
- Genetic testing.

Yes

No

The information in Section III-A applies when a person wants specific SPHI as listed above to be released to their authorized representative, the person must specifically authorize that release.

B. Description of PHI to be released. You may select one or more.

Dates of Services
From: _____ To: _____

<input type="checkbox"/>	Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).			
<input type="checkbox"/>	Claims Information:	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.).			
<input type="checkbox"/>	Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.			
<input type="checkbox"/>	Premium Information:	Includes information related to billing cycles, bank draft changes, etc.			
		Provider/Supplier Name: _____			
<input type="checkbox"/>	Services from Provider or Supplier:	Describe the exact information you want released:			
<input type="checkbox"/>	Other:	Add other information that is not listed above.			

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Section V. Signature & Acceptance of Terms.

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization.

Signature Relationship Date (MM-DD-YY)

Document must be signed by the person, the parent of a minor child or the person's authorized representative. If you are a parent signing on behalf of a minor child, please sign your name – not the child's name. This authorization will expire when the minor child turns 18 years of age, unless proof of legal guardianship is produced. If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and provide copies of the appropriate Legal documents. If these documents are already on file with BCBSTX, you do not need to provide.

Authorized Representative's Name Relationship to Person

Authorized Representative's Address City

State Zip Code Authorized Representative's Area Code & Phone Number

- Before sending this form, make a copy for your records:
- Photocopy this signed authorization, or
 - Complete and sign the duplicate authorization form

Mail the signed authorization to:
Blue Cross and Blue Shield of Texas
PO Box 805107
Chicago, IL 60680-4112

If you need assistance completing the form, refer to the instructions above or call the number listed on your Member ID Card.



**BlueCross BlueShield
of Texas**

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>

BCBSTX provides TDD/TYY services and language assistance for incoming callers for deaf, hard-of-hearing and speech-disabled members. Members can utilize their TeleTYpewriter (TTY) or Telecommunication Device (TDD) to access a teletype operator at 1-800-735-2989.