



INSTRUCTIONS FOR COMPLETING STANDARD AUTHORIZATION FORM

To Complete Form Go to Page 3 of 4

This form should be used when authorizing Blue Cross and Blue Shield of Texas to disclose an individual's Protected Health Information to a specific person or entity. You can follow the instructions provided below or you can call Customer Service at the number listed on your Membership Identification card for assistance. **You must complete all the fields on this form.**

One **Authorization form** can be completed for multiple services and/or providers, but also claim by claim or procedure by procedure within a specified time period. The use of the **Authorization form** is voluntary and can be revoked at any time.

Section I: Name of Individual whose PHI is being released

The purpose of this section is to identify the individual who is requesting the authorization. This individual could be the subscriber, their spouse, a dependent or any other **individual** covered under the subscriber's policy. All fields are required. Example: *Jane Doe is the individual requesting the authorization.*

First Name Jane Last Name Doe Group Number 123456
Social Security Number ###-##-#### Date of Birth 05-10-1962 Identification\Subscriber Number XOP123456789
Address 123 Main Street City Anytown State IL Zip 12345
Area Code & Telephone Number 312-555-1212

Section II: Name of Individual or Organization who is receiving PHI

The purpose of this section is to identify the individual or entity (a family member, close friend, broker, attorney, another trusted party, or organization) that the member named in Section I authorizes to have access to their PHI. If an organization is listed, please identify the name or job title of the person who can receive the PHI, i.e., Benefits Representative, Human Resources Department, XYZ Insurance Agency, etc. Example: *Jane has identified Suzy Smith, her daughter as the person who can receive her PHI.*

I request and authorize Blue Cross and Blue Shield of Texas to disclose my PHI for the purposes described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Persons/Organizations authorized to receive your information Suzy Smith
Relationship Daughter Purpose Assisting in medical care
Address 123 Main Street City Anytown State IL Zip 12345

Section III: Description of PHI being Released (This Authorization CANNOT be used to disclose Psychotherapy Notes)

The purpose of this section is for the individual identified in Section I to select what PHI and in what form do they want released to the person/entity listed in Section II. Section III has 2 parts – both parts must be completed.

Section III A: Release of Health Information protected under State Law

The purpose of III A is for the individual identified in Section I to authorize whether they want certain health information that may have additional protections under state law to be released to the individual/entity listed in Section II. You must select either **"Yes"** or **"No."** Example: Jane has authorized Suzy to receive her health information that may have additional protections under state law.

You **must** check "yes" or "no" if you authorize the release of medical information, test results, records, or communications specific to
(Note: **"yes"** means this information is included in the categories you designate in Part B below.):

Health Information protected under State Law includes:

- Certain Communicable diseases (i.e., Human Immunodeficiency Virus, Sexually Transmitted Diseases and Hepatitis, etc.), Substance Abuse (Drug or Alcohol), Mental Health and Genetic Testing.

☒ Yes
☐ No



Section III B: Release of Protected Health Information (check one or more)

The purpose of this section is for the individual identified in Section I to list the specific types of PHI, BCBSTX can release to the authorized individual identified in Section II. The dates of services must be identified so BCBSTX only releases the information that is being requested. Example: *Jane is authorizing BCBSTX to disclose claims information to Suzy for health care services provided from June 12, 2020, through March 30, 2022.*

		Dates of Services	
		From:	To:
☐ Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).		
☒ 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.).	6-12-20	03-30-22
☐ Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.		
☐ Premium:	Includes information related to billing cycles, bank draft changes, etc.		
☐ Services from (provider or supplier):	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier.)		
☐ Other:	_____ (Specify other information that is not listed in one of the categories above.)		

Section IV: Expiration and Revocation

The purpose of this section is for the individual identified in Section I to provide an expiration date of this authorization form and to acknowledge their right to revoke and terminate the Authorization at any time. All authorizations must contain a specific expiration date or expiration event (e.g., "hospitalization end date" or "rehabilitation end date," etc.). Example: *Jane's authorization will remain valid for one year from the date she signed it or until Jane revokes the authorization.*

Expiration: This authorization will expire on (must choose one):

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

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before the receipt of my written notice of revocation.

Section V: Signature

The purpose of this section is for the individual identified in Section I to sign and date the Authorization. However, if the authorization is being completed by the individual's personal representative identified below; the personal representative must provide documentation as described below. If the individual is a minor dependent under the age of 18, a parent or guardian may sign the authorization form. This form must be signed by the Individual, parent of minor child, or the Individual's personal representative. Example: *Jane signs and dates the form.*

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. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Signature Jane Doe Date (month/day/year): 03-30-22

If you are a Power of Attorney, Legal Guardian, Executor or Administrator completing this form, please complete the following and attach a copy of the legal documents that grant you this authority. Note: if these documents are already on file with BCBSTX, you do not need to attach a copy.

Personal Representative's Name _____ Relationship to Individual _____

Personal Representative's Address _____ City _____ State _____ Zip _____

Personal Representative's Area Code & Telephone Number _____

Final Section

The purpose of this section is to offer suggestions on how to keep a copy of the authorization before you submit to BCBSTX.

BEFORE SENDING AUTHORIZATION FORM YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:

1. MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR
2. COMPLETING AND SIGNING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED



STANDARD AUTHORIZATION FORM TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION

Section I: Name of Individual whose PHI is being released

First Name _____ Last Name _____ Group Number _____
Social Security Number _____ Date of Birth _____ Identification\Subscriber Number _____
Address _____ City _____ State _____ Zip _____
Area Code & Telephone Number _____

Section II: Name of Individual or Organization who is receiving PHI

I request and authorize Blue Cross and Blue Shield of Texas to disclose my PHI for the purposes described below. **I understand that if the person/ organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

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

Section III: Description of PHI being Released *(This Authorization CANNOT be used to disclose Psychotherapy Notes)*

Section III A: Release of Health Information protected under State Law

You **must** check "yes" or "no" if you authorize the release of medical information, test results, records, or communications specific to **(Note: "yes" means this information is included in the categories you designate in Part B below.):**

Health Information protected under State Law includes:

- Certain Communicable diseases (i.e., Human Immunodeficiency Virus, Sexually Transmitted Diseases and Hepatitis, etc.), ☐ Yes
- Substance Abuse (Drug or Alcohol), Mental Health and Genetic Testing. ☐ No

Section III B: Release of Protected Health Information *(check one or more)*

		Dates of Services	
		From:	To:
☐ Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).	_____	_____
☐ 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.).	_____	_____
☐ Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.	_____	_____
☐ Premium:	Includes information related to billing cycles, bank draft changes, etc.	_____	_____
☐ Services from (provider or supplier):	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier.)	_____	_____
☐ Other:	_____ (Specify other information that is not listed in one of the categories above.)		



Section IV: Expiration and Revocation

Expiration: This authorization will expire on *(must choose one)*:

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

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form.

I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before the receipt of my written notice of revocation.

Section V: Signature

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. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Signature _____ Date *(month/day/year)*: _____

If you are a Power of Attorney, Legal Guardian, Executor or Administrator completing this form, please complete the following and attach a copy of the legal documents that grant you this authority. Note: if these documents are already on file with BCBSTX, you do not need to attach a copy.

Personal Representative's Name _____ Relationship to Individual _____

Personal Representative's Address _____ City _____ State _____ Zip _____

Personal Representative's Area Code & Telephone Number _____

Final Section

BEFORE SENDING AUTHORIZATION FORM YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:

1. MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR
2. COMPLETING AND SIGNING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

WHEN COMPLETED AND SIGNED PLEASE MAIL TO:

Blue Cross and Blue Shield of Texas

PO Box 660044

Dallas, TX 75266-0044

If you need assistance completing the form, please refer to the instructions above or contact the Customer Service number listed on your Member Identification Card.

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the Privacy Office.

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 the BCBSTX Customer Advocate Department at the number on the back of your member ID card.

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at **1-855-710-6984**.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

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

Phone: **1-855-664-7270** (voicemail)
TTY/TDD: **1-855-661-6965**
Fax: **1-855-661-6960**
Email: civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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

US Dept of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: **1-800-368-1019**
TTY/TDD: **1-800-537-7697**
Complaint Portal: ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>

This notice is available on our website at <https://www.bcbstx.com/medicaid/pdf/medicaid-non-discrimination-tx.pdf>

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **1-855-710-6984** (TTY: **711**) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-855-710-6984 (TTY: 711) 或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસિયલ સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-710-6984 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-855-710-6984 (TTY: 711) o rivolgiti a un assistente.
한국어 Korean	주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-855-710-6984 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'it'áá jiik'eh ná hólǫ. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'í'ígíí éí t'áá jiik'eh hólǫ. Kohjǫ' 1-855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'í' hanidzihi.
فارسی Farsi	توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-855-710-6984 (TTY: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libheng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجه دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-855-710-6984 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-710-6984 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.