BlueCross BlueShield of Texas

Standard Authorization Form to Release Protected Health Information (PHI)

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.

LegalEase Digital Imaging LLC _____

Persons/Organizations authorized to receive your information _____ Relationship _____

Litigation _____

Purpose

2496 Meadowcroft Dr _____ *Burton* _____ MI _____ 48519 _____

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:**
☐ 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 Information:	Includes information related to billing cycles, bank draft changes, etc.		
☐ Services from Provider or Supplier:	Provider/Supplier Name: _____ Describe the exact information you want released:		
☐ 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.*

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.*

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.