Authorization for Release of Personal & Health Information

Blue Shield of California and/or Blue Shield of California Life & Health Insurance Company (Blue Shield) require specific written authorization for the disclosure of any personal and health information, beyond that which is necessary to provide treatment, to facilitate payment, or to perform operations of the health plan or insurer, to the extent permitted by law. Blue Shield will only disclose that information which is reasonably necessary to achieve the purpose of the request for release.

1. I, the Undersigned, Authorize:

Blue Shield

2. To Release Information from the Records of:

Member Name:_____

Member Date of Birth: _____ Subscriber #: _____

3. Information Authorized for Release (check all that apply):

- ❑ Address Change
- ❑ Member/Dependent change
- ❑ Dues Payment & Billing information
- ❑ Medical care and treatment
- ❑ Dental care and treatment
- ❑ Other (please specify) _____

_____

- ❑ Policy or Contract Change
- ❑ PCP Change
- ❑ Claims information
- ❑ Vision care and treatment

** If this authorization is for mental health, substance abuse, or HIV information, a separate completed authorization form will be necessary for the release of information (1) protected by the LPS Act or (2) containing HIV results. Further, the LPS Act often requires that both the patient's treating physician and the patient sign the authorization form before information may be released.*

4. Information may be Released to:

Name of individual or organization: _____

Relationship: _____

Name of individual or organization: _____

Relationship: _____

5. Purpose & Limitations of the Authorization: By signing this form, you authorize the use and disclosure of the personal & health information above by a third party for the following purpose; please also list any limitations you would like to place on the use of this information:

_____

6. Signature – You may refuse to sign this authorization.

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that by signing this form, I am confirming my authorization that Blue Shield may use and/or disclose to the persons and/or organizations named in the information described in this form for the purposes stated. I understand that if the persons or organizations I authorize to receive and/or use the personal and health information described above are not health plans, covered health care providers or healthcare clearinghouses subject to federal health information privacy laws, they may further disclose the personal and health information and it may no longer be protected by federal health information privacy laws.

Signature: _____ Date: _____

Print Name: _____

7. Expiration: This authorization will expire on: ___/___/___ A specific date is required.
If a date is not provided, then the authorization will expire one year from the signature date.

Expiration and Revocation: This authorization will expire one year from the date of signature, or on the date you specify. If you sign this form, you may revoke the authorization at any time by notifying Blue Shield in writing at the address listed below. Revoking this authorization will not have any effect on actions that Blue Shield took in reliance on the authorization before we received the notification. Note: If this authorization is for a minor, the expiration date cannot exceed the 18th birthday of that minor.

Treating Physician (signature may be necessary if related to mental health, substance abuse, or HIV care)

Physician Signature: _____ Date: _____

Print Name: _____

8. Person or Entity Authorizing Disclosure of Information: If you are signing on behalf of the member, please indicate your relationship to the member and provide copies of verification of your legal right to authorize the disclosure of the member's personal and health information.

- ❑ Court Appointed Guardian, legal conservator, legal representative or Durable Power of Attorney for Health Care
- ❑ Spouse or person financially responsible
- ❑ Beneficiary or personal representative of deceased
- ❑ Parent or guardian of minor patient

This authorization is voluntary. Blue Shield places no conditions on our payment activities in connection with your claims, your enrollment in a health plan or your eligibility for benefits because you have given this authorization. You may refuse to sign this authorization. You can request a copy of this authorization after you sign it. A copy of this authorization shall be considered as effective and valid as the original.

Return completed authorization form to:

Blue Shield of California, Attn: Customer Service, PO Box 272540, Chico, CA 95927