Authorization for Disclosure of Health Information

Please read these instructions carefully before completing this form.

When to Use This Form

Complete this form if you are requesting Blue Cross to release information about you to another person or entity.

Parents or a legal guardian may sign for a minor unless the minor is permitted under state law to consent to the treatment. In that case, the minor must sign the authorization.

How to Complete This Form

Section 1:

- Fill in the name, address, member identification and date of birth of the person whose information will be disclosed.
- Provide the date range of records to be disclosed. The "From" and "To" areas must be entered as dates (mmddyyyy). An actual date must be entered in the "From" and "To" fields. For example: From "07/01/2018 To 12/31/2018".

Note: If "From" and "To" dates are left blank, the form is considered valid for all service dates on file for the member.

Section 2 and 3:

- Check the boxes to identify the type(s) of information you want us to disclose.
- You must enter the purpose for which you want the information disclosed.
  For example, I need help understanding my claims.

Section 4:

- Fill in the name and address of the Individual, Organization, or Provider.

Section 5:

This form must be completed and signed by one of the following:

- The person whose information will be released.
- The parent or legal guardian of a minor whose information will be released except as noted above.
- The personal representative of the person whose information will be released (e.g., power of attorney, conservator, executor).

Note: If expiration date or specific event is not entered, this authorization will end one year from the date this form is signed.

Return this completed form to

Blue Cross and Blue Shield of Minnesota
P.O. Box 982803
El Paso, TX 79998-2803
Fax: 651-662-7933

BlueCross BlueShield Minnesota

Authorization for Disclosure of Health Information

This form is used to authorize Blue Cross to release your protected health information to another person or entity.

Section 1 The individual whose information may be disclosed:

Patient/Member First Name	Patient/Member Last Name	Pt/Mbr Date of Birth (mm/dd/yyyy) / /
Patient/Member Address 1		
Patient/Member Address 2		
Patient/Member City	Pt/Mbr State	Pt/Mbr Zip Code
Patient/Member Identification Number	Telephone	

The information authorized to be disclosed is from the following period(s). If "From" and "To" dates are left blank, the form is considered valid for all service dates on file for the member.

From (mm/dd/yyyy)	To (mm/dd/yyyy)
From (mm/dd/yyyy)	To (mm/dd/yyyy)

Section 2

☐ Check if this authorization is for chemical dependency program information.

☐ Check if this authorization is for psychotherapy notes.

Section 3 Information to be disclosed (Please check only that which applies):

Designated Record Set: (Please check only that which applies)

☐ Enrollment Information ☐ Claims Information ☐ Appeal Information

☐ Care/Case Management Information ☐ All health information (including any medical records that we may have) ☐ Billing Information

☐ Only health information related to the following condition(s): _____

_____

_____

☐ Other _____

What is the reason for this disclosure? _____

_____

Section 4 This information is to be disclosed to:

☐ Individual, Organization or Provider is my Authorized Representative

Individual, Organization or Provider

(include address if information is to be mailed)

Section 5 I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Cross and Blue Shield of Minnesota and Blue Plus. I understand that revocation of this authorization will not affect any action Releaser took in reliance on this authorization before it received my written notice of revocation. I also understand that without my written authorization, Releaser may not use or disclose my health information for any reason except those described in Releaser's Notice of Privacy Policies and Practices. This authorization will end one year from the date this form is signed unless I indicate an earlier date or event here:

Expiration date (mm/dd/yyyy) or specific event

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Releaser, its subsidiaries, affiliates, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Sign only **one** of the signatures below:

Signed: (Patient/Member)	**OR**	**Signed:** (Personal Representative)
Date (mm/dd/yyyy)		Date (mm/dd/yyyy)

(Include a description/documentation of such representative's authority to act for the patient)

Please mail the completed form to: Blue Cross and Blue Shield of Minnesota
P.O. Box 982803
El Paso, TX 79998-2803

This form can also be faxed to (651) 662-7933