Authorization for Disclosure of Health Information (ADHI)

BlueCross BlueShield Minnesota

Please read these instructions carefully before completing this form.

When to use this form:

- Complete this form if you are requesting Blue Cross and Blue Shield of Minnesota to release your information to another person or entity.
- Parents or legal guardians may sign for a minor (under age 18) unless the minor is permitted under state law to consent to the treatment (authorized for release in this disclosure). In that case, the minor must sign.
- This form will be valid for one year from the date in which it is signed, unless an earlier expiration date or specific event is indicated below.

How to complete this form:

Section 1 (The individual whose information may be disclosed):

- Fill in the name, address, member identification number, date of birth, and telephone number of the person whose information will be disclosed.

Section 2 (The information to be disclosed):

- Check the boxes to identify the type(s) of information you want us to disclose.
    - If you check the "All Information" option, this includes any medical records that we may have.
    - If you check the "Information only related to the following conditions" options, you must write in additional information.
    - If you check the "other" option, you must write in additional information.
    - Provide the date range of records being disclosed. The "From" and "To" areas must be entered as days (mmddyyyy). An actual date must be entered in the "From" and "To" fields.

Section 3 (Who can receive your information):

- Fill in the name and address of the individual, organization or provider you are authorizing to receive the type of health information you indicated in Section 2 of this form.
- Check the box within this section if you would like to authorize the mailing of your information to the authorized individual, organization or provider.

Section 4 (Authorization):

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: This authorization will end one year from the date this form is signed unless an earlier expiration date or specific event is indicated.

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

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Authorization for Disclosure of Health Information

This form is used to authorize Blue Cross to release your Protected Health Information (PHI) to another person or entity.

BlueCross BlueShield Minnesota

Section 1: The individual whose information may be disclosed

Member First Name	Member Last Name	Mbr Date of Birth (mm/dd/yyyy)
Member Address 1		
Member Address 2		
Member City	Member State	Member ZIP Code
Member ID Number	Member Telephone Number	

Section 2: The information to be disclosed

Please check any or all type(s) of information that you would like us to disclose:

- ☐ ALL information (including any medical records that we may have)
- ☐ Claim information
- ☐ Appeal information
- ☐ Care/Case management information
- ☐ Billing information
- ☐ Enrollment information

Note: You must write additional information if you select any of the two checkboxes below

- ☐ Information only related to the following conditions: _____
- ☐ Other: _____

Please check any or all if applicable:

- ☐ If this authorization is for chemical dependency program information
- ☐ If this authorization is for psychotherapy notes

Please provide the date range of the records to be disclosed:
(If date range is not selected, health information from any date may be disclosed)

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

Section 3: Who can receive your information?

This information is to be disclosed to:

☐ Individual ☐ Organization (i.e. health system, business) ☐ Provider (i.e. doctor, midwife)

List the name of the individual, organization, or provider

Address

☐ Check to authorize mailing of information if requested by authorized individual or provider

Section 4: Authorization

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 expiration date or event below:

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: (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 or emailed to Incoming.Service.Center@bluecrossmn.com