Standard Authorization Form
To Use or Disclose
Protected Health Information (PHI)

I. Individual (Name and information of person whose protected health information is being disclosed):

Name _____ **Date of Birth** _____

Group # _____ **Identification/Subscriber #** _____ **Social Security Number** _____

Address _____ **City** _____ **State** _____ **ZIP** _____

Area Code & Telephone Number _____

II. Authorization and Purpose:

I request and authorize Blue Cross Group Medicare Advantage Open Access (PPO)℠ to disclose my protected health information as 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** _____

III. Specific Description of Information to be Used or Disclosed (*Please Complete **Parts A and B** in this Section*)

This Authorization CANNOT be used to disclose Psychotherapy Notes.

Information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

A. Release of Sensitive Protected Health Information 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)***:

- 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

Yes ☐ **No** ☐

- Genetic testing.

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	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.)		

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 the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative)**:**

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 signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents.

Personal Representative's Name	Relationship to Individual

Personal Representative's Address	City	State	ZIP

Personal Representative's Area Code & Telephone Number

BEFORE RETURNING 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

Mail your completed signed authorization to:
Blue Cross Medicare Advantage[SM]
c/o Member Services
P.O. Box 4555
Scranton, PA 18505

If you need assistance completing the form, please contact the Customer Service number listed on the back of your Member Identification Card.

This information is available for free in other languages. Please call our Customer Service number at 1-866-390-4276 (TTY/TDD users should call 711). We are open between 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Esta información está disponible en otros idiomas de forma gratuita. Comuníquese a nuestro número de Servicio al cliente al 1-866-390-4276 (los usuarios de TTY/TDD deben llamar al 711). Nuestro horario es de 8 a.m. - 8 p.m., hora local, los 7 días de la semana. Si usted llama del 15 de febrero al 30 de septiembre, durante los fines de semana y feriados, se usarán tecnologías alternas (por ejemplo, correo de voz).

Blue Cross Medicare Advantage℠ and Blue Cross MedicareRx℠ plans comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Medicare Advantage and Blue Cross MedicareRx plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross Medicare Advantage and Blue Cross MedicareRx plans:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross Medicare Advantage and Blue Cross MedicareRx plans have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-774-8592 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-774-8592 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-774-8592 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-774-8592（TTY：711）。

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-774-8592 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-774-8592 (TTY: 711) 번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-774-8592 (رقم هاتف الصم والبكم: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-774-8592 (TTY: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-774-8592 (TTY: 711)

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-774-8592 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-774-8592 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-774-8592 (ATS: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-774-8592 (TTY: 711) पर कॉल करें।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-774-8592 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-774-8592 (TTY: 711) تماس بگیرید

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-774-8592 (TTY: 711).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-877-774-8592 (TTY: 711).