BlueCross BlueShield of Illinois

Instructions for Completing Standard Authorization Form

To Complete Form go to Page 4 of 5

This form should be used when authorizing Blue Cross Blue Shield of Illinois (BCBSIL) to disclose an individual's protected health information (PHI) to a specific person or entity. You can follow the instructions provided below or you can call Customer Service at the number listed on your Membership Identification card for assistance. **You must complete all the fields on this form.**

One **Authorization form** can be completed for multiple services and/or providers, but also claim by claim or procedure by procedure within a specified time period. The use of the **Authorization form** is voluntary and can be revoked at any time.

Section I:
*The purpose of this **section** is to identify the individual who is requesting the authorization. This individual could be the subscriber, their spouse, a dependent or any other **individual** covered under the subscriber's policy. All fields are **required**. Example: Jane Doe is the individual requesting the authorization.*

Section I. Name of Individual whose PHI is being released

Jane Doe		05-10-1962
Name		**Date of Birth**
123456	**XOP123456789**	**###-##-####**
Group #	**Identification/Subscriber #**	**Social Security Number**

123 Main Street	Anytown	IL	12345
Address	**City**	**State**	**ZIP**

312-555-1212
Area Code & Telephone Number

Section II:
The purpose of this section is to identify the individual or entity (a family member, close friend, broker, attorney, another trusted party, or organization) that the member named in Section I authorizes to have access to their PHI. If an organization is listed, please identify the name or job title of the person who can receive the PHI, i.e., Benefits Representative, Human Resources Department, XYZ Insurance Agency, etc. Example: Jane has identified Suzy Smith, her daughter as the person who can receive her PHI.

Section II. Name of Individual or Organization who is receiving PHI

I request and authorize Blue Cross and Blue Shield of Illinois to disclose my PHI for the purposes 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.**

Suzy Smith	Daughter	Assisting in medical care	
Persons/Organizations authorized to receive your information	**Relationship**	**Purpose**	
456 Mill Road	**Happytown**	**IL**	**45678**
Address	**City**	**State**	**ZIP**

Section III. Description of PHI being Released *(This Authorization CANNOT be used to disclose Psychotherapy Notes)*

***Section III**:*
The purpose of this section is for the individual identified in Section I to select what PHI and in what form do they want released to the person/entity listed in Section II. Section III has 2 parts – both parts must be completed.

***Section III A**. The purpose of III A. is for the individual identified in Section I to authorize whether they want certain health information that may have additional protections under state law to be released to the individual/entity listed in Section 11. You must select either "**Yes**" or "**No.**" Example: Jane has authorized Suzy to receive her health information that may have additional protections under state law.*

Section III A. Release of Health Information protected 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)***:

Health Information protected under State Law includes:

- Certain Communicable diseases (i.e., Human Immunodeficiency Virus, Sexually Transmitted Diseases and Hepatitis, etc.), Substance Abuse (Drug or Alcohol), Mental Health and Genetic Testing.

Yes ☒

No ☐

Section III B*. The purpose of this section is for the individual identified in Section I to list the specific types of PHI, BCBSIL can release to the authorized individual identified in Section II. The dates of services must be identified so BCBSIL only releases the information that is being requested. Example: Jane is authorizing BCBSIL to disclose claims information to Suzy for health care services provided from June 12, 2020, through March 30, 2022.*

Section III 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 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.).	6-12-20	03-30-22
☐	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.)		

Section IV. Expiration and Revocation

Section IV*: The purpose of this section is for the individual identified in Section I to provide an expiration date of this authorization form and to acknowledge their right to revoke and terminate the Authorization at any time. All authorizations must contain a specific expiration date or expiration event (e.g., "**hospitalization end date**" or "**rehabilitation end date**," etc.). Example: Jane's authorization will remain valid for one year from the date she signed it or until Jane revokes the authorization.*

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 taken in reliance on this authorization before the receipt of my written notice of revocation.**

V. Signature

Section V*: The purpose of this section is for the individual identified in Section I to sign and date the Authorization. However, if the authorization is being completed by the individual's personal representative identified below; the personal representative must provide documentation as described below. If the individual is a minor dependent under the age of 18, a parent or guardian may sign the authorization form. This form must be signed by the Individual, parent of minor child, or the Individuals person representative. Example: Jane signs and dates the form.*

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.

Jane Doe _____ 03-30-22 _____

Signature **Date: month/day/year**

If you are a Power of Attorney, Legal Guardian, Executor or Administrator completing this form, please complete the following and attach a copy of the legal documents that grant you this authority. Note: if these documents are already on file with BCBSIL, you do not need to attach a copy.

Personal Representative's Name **Relationship to Individual**

Personal Representative's Address **City** **State** **ZIP**

Personal Representative's Area Code & Telephone Number

Final Section: *The purpose of this section is to offer suggestions on how to keep a copy of the authorization before you submit to BCBSIL.*

BEFORE SENDING AUTHORIZATION FORM
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

BlueCross BlueShield of Illinois

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

I. Name of Individual whose PHI is being released

Name		Date of Birth
Group #	Identification/Subscriber #	Social Security Number

Address	City	State	ZIP

Area Code & Telephone Number

II. Name of Individual or Organization who is receiving PHI

I request and authorize Blue Cross and Blue Shield of Illinois to disclose my PHI for the purpose 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. Description of PHI being Released (*This Authorization CANNOT be used to disclose Psychotherapy Notes*)

A. Release of Health Information protected 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)***:

Health Information protected under State Law includes:

- Certain Communicable diseases (Human Immunodeficiency Virus, Sexually Transmitted Diseases and Hepatitis, etc.), Substance Abuse (Drug or Alcohol), Mental Health and Genetic Testing.

Yes ☐

No ☐

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. You do NOT have to attach copies of these documents if they are already on file with Blue Cross and Blue Shield of Illinois:

_____ _____

Personal Representative's Name **Relationship to Individual**

_____ _____ _____ _____

Personal Representative's Address **City** **State** **ZIP**

_____

Personal Representative's Area Code & Telephone Number

BEFORE RETURNING THIS FORM YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:

(1) MAKING A PHOTOCOPY OF THE SIGNED AUTHORIZATION; OR
(2) COMPLETING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

Mail your completed signed authorization to:
Blue Cross and Blue Shield of Illinois
P.O. Box 660044
Dallas, TX 75266-0044

If you need assistance completing the form, please refer to the instructions above or contact the Customer Service number listed on your Member Identification Card.

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the HCSC Privacy Office.