BlueCross BlueShield of Mississippi

Committed to a Healthier Mississippi.

Return by fax to 601-664-4093 or mail to:
Blue Cross & Blue Shield of Mississippi
P.O. Box 1043
Jackson, MS 39215-1043

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is used to authorize Blue Cross & Blue Shield of Mississippi (BCBSMS) to disclose a Member's Protected Health Information to the individuals or organizations named in this form. See second page for instructions.

A. MEMBER INFORMATION – This is the individual whose information will be released. (Individuals over 18 years of age must complete their own form, except for legal Personal Representative situations.)

Member's Name: _____

Address (Street, City, State, and Zip Code): _____

Telephone Number: _____ Member's I.D. Number: _____
(as it appears on I.D. card)

B. AUTHORIZED PARTY – This is the person or organization who will receive the Member's information.

I authorize BCBSMS to release the above Member's Protected Health Information to:

_____ _____

_____ _____

C. INFORMATION TO BE RELEASED – If limiting disclosures, please describe. ***Check one box only*.**

☐ ALL information relating to provision or payment of healthcare benefits or services may be released.

☐ Other (please describe): _____

D. EXPIRATION AND REVOCATION - When this Authorization will end. ***Check one box only*.**

Expiration: *(check one box only)*

☐ Six (6) months after termination of BCBSMS coverage. (This option will apply if no other expiration is specified.)

☐ On this specific date _____ or occurrence of this event: _____

Revocation: You may revoke this Authorization at any time by notifying BCBSMS in writing. Your revocation will not affect any action BCBSMS took before your revocation was received. To revoke this Authorization, contact the BCBSMS Privacy Office.

E. MEMBER SIGNATURE – Please sign and date below.

This Authorization is voluntary and completed at my own request. I understand that if the person or organization I have authorized to receive the information is not subject to federal health information privacy laws, the information may be re-disclosed and no longer be protected by federal privacy laws. I understand that giving this Authorization is not a condition of enrollment in a health plan or eligibility for benefits. This Authorization is not valid unless completely filled out, signed and dated by the Member or by the Member's legal Personal Representative.

_____ _____

Signature of Member (or Member's Personal Representative) ** **Date**

** If the Member is a dependent minor child, the child's parent or legal guardian must sign this form. This form may ***not*** be signed on behalf of the Member by a spouse or parent of an individual 18 years of age or older unless they are the Member's legal Personal Representative and provide proof of this legal authority to BCBSMS.

F. PERSONAL REPRESENTATIVE INFORMATION – If you are signing this Authorization as the Member's Personal Representative, please complete this section and attach a copy of the legal document establishing this authority (except for parent of minor, dependent child).

Name of Personal Representative: _____

Relationship to the Member:

☐ Parent of dependent minor child (copy of legal document is not necessary)

☐ Legal guardian or conservator ***

☐ Health Care Power of Attorney ***

☐ Executor or Administrator of Estate ***

☐ Other: _____ ***

*** Other than the parent of a dependent minor child, all other Personal Representatives must attach proof of their legal authority to this Authorization, unless these legal papers are already on file at BCBSMS.

PLEASE DO NOT RETURN THIS PAGE, only the completed and signed Authorization form.

Instructions for completing the Authorization Form:

The Authorization Form is used by a Member (or Member's Personal Representative) to authorize Blue Cross & Blue Shield of Mississippi (BCBSMS) to release the Member's Protected Health Information to another person or organization. This form is used when the information is being released for purposes other than treatment, payment, or healthcare operations, or when the Member wishes for another person or organization to be able to receive the Member's information from BCBSMS.

Section A: MEMBER INFORMATION: Fill in the information requested in this section concerning the Member whose information will be released. In providing the Member's I.D. number, be sure to include any letters that appear at the beginning or end of the I.D. number. (I.D. number examples: 812345678**M** or **R**1234567)

Section B: AUTHORIZED PARTY: This section identifies the person or organization who will receive the Member's information from BCBSMS. Describe the authorized person or organization as specifically as possible. (Examples: Jane Smith, Jim Doe, Enrollment Coordinator at the Social Security Administration, Director of Claims at AXYZ Life & Accident Company)

Section C: INFORMATION TO BE RELEASED: Select the check box that best describes the information that may be released. Select the first check-box if there is no restriction of information that may be released to the authorized person or organization, including information such as claims, EOBs, benefits, membership, premium or billing information. Select the second check-box, "Other," if you wish to limit the information released, and then fully describe the limitation. (Examples: info about back injury in October 2007; car accident on 2/01/2008; prescriptions purchased from 01/01/2006 to 09/30/2007; physical therapy claims only, etc.)

> **Note:** If the information to be released includes psychotherapy notes (as defined by HIPAA , the Health Insurance Portability and Accountability Act of 1996), you are not permitted to use the same Authorization form to authorize the release of any other protected health information. Since psychotherapy notes are not a part of any patient's medical record, BCBSMS having such information in its possession is very unlikely. You can contact the BCBSMS Privacy Office at 601-664-5456 if you have questions concerning an authorization for the release of psychotherapy notes.

Section D: EXPIRATION AND REVOCATION: Expiration: Select the first check-box if you wish for the Authorization to remain valid as long as the BCBSMS coverage is in effect and for 6 months after the coverage terminates. This option will also apply if no other expiration date or event is specified. Select the second check-box if you want the Authorization to expire on a specific date or the occurrence of a specific event. (Examples of expiration events: settlement of lawsuit concerning car accident on 2/01/2008; final decision on disability claim, etc.) **Revocation:** An Authorization may be revoked at any time by notifying BCBSMS in writing. For assistance with revoking an Authorization, contact the BCBSMS Privacy Office at 601-664-5456. Revoking an Authorization will not affect any action taken prior to receiving the written revocation request.

Section E: MEMBER SIGNATURE: Individuals over the age of 18 must sign their own Authorization form, unless the form is submitted by a legal Personal Representative (see Section F below). If the Member is a dependent minor child, the child's parent or legal guardian must sign the form. A legally emancipated minor may sign their own form. This form may *not* be signed on behalf of a Member by a spouse or parent of an individual 18 years or older, unless they are the Member's legal Personal Representative and provide proof of this legal authority to BCBSMS.

Section F: PERSONAL REPRESENTATIVE INFORMATION: A Member's Personal Representative is a person who has the legal authority to act on the Member's behalf. (Examples: parent of a dependent minor child, legal guardian, Health Care Power of Attorney, Executor or Administrator of a Deceased Person's Estate, Conservator of an Incapacitated Person's Estate, etc.) Except for the parent of a dependent minor child, the legal authority of a Personal Representative is typically granted by a court-order or other legal document. Other than the parent of a dependent minor child, all other Personal Representatives must provide proof of their legal authority to BCBSMS by attaching a copy of the legal papers to this Authorization, unless these papers are already on file at BCBSMS.

Mail the completed and signed Authorization form to: Blue Cross & Blue Shield of Mississippi, P.O. Box 1043, Jackson, MS, 39215-1043, or FAX the form to 601-664-4093. You should keep a copy of the form for your records.