BlueCross BlueShield of Oklahoma

A Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans
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www.bcbsok.com

Authorization to Disclose Protected Health Information

Subscriber Medical ID #: ______________________ (as it appears on ID card)

Subscriber Dental ID #: ______________________ (as it appears on ID card)

I. Individual (Name, telephone number, date of birth and SSN of person authorizing disclosure):

Name: ______________________

Date of Birth: ______________________

Social Security #: ______________________

Telephone #: (   ) ______________________

II. Authorization:

I request and authorize Blue Cross and Blue Shield of Oklahoma 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
______________________	______________
______________________	______________
______________________	______________

III. Specific Description of Information to be Used or Disclosed (check one or more):

☐ 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 services you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions, claim payment or denial reasons, etc.).

☐ Authorization Information — Includes information regarding precertification and authorization, including specific medical information related to requests and determinations.

☐ Premium Information — Includes information related to billing cycles, bank draft changes, etc.

☐ Services on [date(s)] — from: ______________ to: ______________
(Includes information related to services that occurred during the specific time frame)

☐ Services from (provider or supplier): ______________________
(Includes information related to services rendered by a specific provider or supplier)

☐ Other ______________________
(Specify other information authorized for disclosure if it is not listed in one of the categories above)

This Authorization CANNOT be used to disclose Psychotherapy Notes

PLEASE COMPLETE THE BACK OF THIS FORM

IV. Expiration and Revocation:

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed ☐ On the following date: ______________________

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 acknowledge that, in accordance with state law, **the information authorized for disclosure may include information which may be considered a communicable or venereal disease, which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

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.

X ______________________________ ______________________
Signature Date

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

BEFORE RETURNING
YOU MAY WISH TO MAKE A COPY OF THIS SIGNED AUTHORIZATION FOR YOUR RECORDS

Mail your completed signed authorization to:

Customer Service/Privacy Department
Attention: Authorization Clerk
P.O. Box 3283
Tulsa, OK 74102-3283

Internal or Third Party Use Only

*Must be completed by a health plan, health care provider or third party **if** the authorization is requested:*

The purpose of the use or disclosure ______________________________

☐ At the Request of the Individual