Authorization for Release of Medical Information to Primary Applicant

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Instruction to Applicants
This form authorizes Blue Cross Blue Shield of North Dakota (BCBSND) to disclose to the primary applicant medical information used in pre-enrollment underwriting or risk-rating or to determine eligibility for enrollment in or benefits under a health plan, as may be needed to explain its underwriting decision with respect to members of the primary applicant's family. Each individual age 12 and over, for whom the primary applicant is applying for health plan coverage, should sign this authorization. **If a legal representative (e.g. Power of Attorney, Legal Guardian, etc.) signs this authorization on behalf of an individual, include a copy of the power of attorney or other relevant document evidencing the authority to represent the individual.**

By signing this form, I authorize BCBSND to disclose medical information used in pre-enrollment underwriting or risk-rating or used to determine eligibility for enrollment in or benefits under a health plan to the primary applicant as may be needed to explain its underwriting decision. I understand that completion of this form is entirely voluntary. My refusal to authorize disclosure of medical information to the primary applicant will have no effect on my enrollment in a health plan, my eligibility for benefits under a health plan or the amount BCBSND will pay for the health services I receive. I understand that whether or not I elect to complete this form will have no effect on the ability of a personal representative, such as a parent, guardian, or person acting in the capacity of a parent or guardian, to have access to my medical information when applicable law allows such access without my written permission.

I understand that this authorization applies to use and disclosure of medical information and records that may relate to sexually transmitted disease, use of contraceptives, prenatal care, termination of pregnancy, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), treatment for alcohol or drug abuse, and receipt of behavioral or mental health services.

I understand that if the recipient of this medical information is not a health care provider or health plan covered by federal privacy regulations, this medical information may be re-disclosed and no longer protected by these federal regulations. BCBSND is subject to federal privacy regulations and will not re-disclose this medical information except as allowed by law.

I understand that I have the right to revoke or end this authorization at any time. I understand that in order to revoke this authorization I must do so in writing to BCBSND. I understand that my revocation of this authorization will not affect any action that has been taken, or any medical information that has already been used or disclosed, based upon this authorization before BCBSND actually received my revocation. This authorization will remain in effect for the earlier of 12 months from the date of signature or the earlier date entered here: _____.
I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am authorizing the use and/or disclosure of medical information as described in this form. **I agree that a copy of this Authorization shall be as valid as the original.**

Primary Applicant Information

Spouse Information	
Spouse's Name	Birth Date (MM/DD/YYYY)
Signature	Date (MM/DD/YYYY)

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Dependent Information (Children Age/12 and over)	
Dependent's Name	Birth Date (MM/DD/YYYY)
Signature	Date (MM/DD/YYYY)
Dependent's Name	Birth Date (MM/DD/YYYY)
Signature	Date (MM/DD/YYYY)
Dependent's Name	Birth Date (MM/DD/YYYY)
Signature	Date (MM/DD/YYYY)
Dependent's Name	Birth Date (MM/DD/YYYY)
Signature	Date (MM/DD/YYYY)

You are entitled to a copy of this authorization after you sign it.

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