Authorization to Release Information Form

Section A: Member information *(Please type or print clearly. This Member should sign Section F.)*

Member name: _____ *Birth date:* _____

Address: _____

City: _____ *State:* _____ *Zip:* _____

Day telephone: _____ *Plan number(s):* _____

Section B: Purpose of form

Please state the purpose(s) of this authorization below:

_____

_____

_____

Section C: Type of information

I understand that, by completing this form, I am allowing you to use my health information with and disclose it to person(s) and/or organization(s) designated on this form. I understand that the health information in my records may include information relating to (please strike through any of the following health information you do not want to be available to those you designate on this form):

- *sexually transmitted disease;*
- *acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV);*
- *alcohol, drug or other substance abuse;*
- *behavioral or mental health;*
- *other sensitive medical information that applicable law may protect from use or disclosure without the Member's permission.*

Please describe in as much detail as possible the information that this authorization will allow to be used and/or disclosed. For example, the information to be used or disclosed may be related to payment, enrollment, or claims. If so, you should include the types of claims, dates of service, or types of service, if available.

_____

_____

_____

Completion of this form is entirely voluntary. Your refusal to authorize disclosure of your health information to the person(s) and/or organization(s) designated on this form will have no effect on our enrollment of you in our health plans, your eligibility for benefits under our health plans, or the amount we pay for the health services you receive. Please note that whether or not you 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 certain of your health information when applicable law allows such access without your written permission.

Section D: Authorized use and/or disclosure

<u>Authorized to release the information</u>: By signing this form I am allowing Blue Cross Blue Shield of North Dakota to use and disclose my health information with those I have authorized to receive the information.

<u>Authorized to receive the information</u>: Name or specifically identify the person(s) and/or organization(s), which this authorization will allow to receive and use the protected health information described above.

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_____

I understand that, if the person(s) and/or organization(s) is not subject to federal or applicable state privacy laws, my health information may no longer be protected by those privacy laws, and the person(s) and/or organization(s) may further disclose my health information without my authorization. I acknowledge that my authorization is voluntary.

Section E: Expiration and revocation

This authorization will be valid for this one time release of information unless otherwise specified below. Any date specified cannot exceed 12 months from the date of the covered Member's signature below.

_____

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 <u>in writing</u> by giving written notice of my decision to Member Services at the address listed below. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it. I also understand that my revocation may not be effective in preventing release of certain health information to a personal representative, such as a parent, guardian, or person acting in the capacity of a parent or guardian, who applicable law allows to have access to such health information without my written permission.

Section F: Signature/authorization of Member listed in Section A

*Signature:*_____ *Date:*_____

UPON REQUEST, YOU ARE ENTITLED TO A COPY OF THIS FORM AFTER YOU SIGN IT.
Please notify us of any changes to the information provided on this form.
If you have questions, please contact us at 1-800-342-4718

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An independent licensee of the Blue Cross & Blue Shield Association

Please return form to: 4510 13th Ave S | Fargo, ND 58121
or
Fax to: (701) 282-1888