AUTHORIZATION TO RELEASE INFORMATION FORM

Authorization to Disclose Health Information (ADHI) (Medical Coverage)

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 call the number on the back of your member ID card.

Return completed forms by:

- Fax: (701) 282-1888
- Mail: BCBSND
  4510 13th Ave S
  Fargo, ND 58121

Section A: Purpose of Form

This form is used to request and authorize Blue Cross Blue Shield of North Dakota to use and disclose my health information with another person or entity.

Section B: Member Information

Please type or print clearly. This individual should sign Section F.

Member ID		Daytime Phone Number		
Last Name	First Name	MI	Suffix	Birth Date (*mm/dd/yyyy*)
Address				
Apartment/Unit/Lot/Suite				
City		State		Zip Code

Section C: Authorized Use and/or Disclosure

By signing this form, I am allowing Blue Cross Blue Shield of North Dakota to use and disclose my health information as outlined in Section D with the following individual(s) and/or organization(s) listed below.

I understand that if the individual(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 individual(s) and/or organization(s) may further use and disclose my health information without my authorization. I acknowledge that my authorization is voluntary.

Individual or Entity Name		Phone Number
Address		
Apartment/Unit/Lot/Suite		
City	State	Zip Code

PLEASE COMPLETE ALL PAGES OF THIS FORM.
If you have questions, please call the number on the back of your member ID card.

4510 13th Avenue South, Fargo, North Dakota 58121

Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross Blue Shield Association

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Section D: Type of Information

I allow the following information to be used or disclosed by BCBSND on my behalf **(CHECK ONLY ONE BOX)**:

☐ **Psychotherapy Notes**: Federal law requires a separate authorization to use or release psychotherapy notes. If you check this box, you may not check another box below.

OR

☐ **All My Information**: Includes health diagnosis, claims, doctors, premium billing and payment information, including maternity, sexually transmitted disease, AIDS, HIV, alcohol, drug or other substance abuse, behavioral and mental health and other sensitive medical information that applicable law may protect.

OR

☐ **Only Limited Information** (*Check all that apply*):

- ☐ Appeal information
- ☐ Benefits and coverage
- ☐ Premium billing and payment
- ☐ Claims and payment
- ☐ Other: _____
- ☐ Eligibility and enrollment
- ☐ Pre-certification and pre-authorization
- ☐ Referral
- ☐ Pharmacy

Note: Certain Federal and State laws require that you give specific permission to use or release the information below, even if you checked a box above. Indicate your permission for the disclosure of the following information by checking all that apply:

- ☐ Alcohol/substance abuse*
- ☐ Other: _____

* I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulation and cannot be used or disclosed without my written consent unless otherwise provided for in the laws and regulations.

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.

☐ Valid for one year from the signature date in Section F.

☐ Earlier than one year and upon the date or event described below:

_____

I may revoke this authorization at any time by giving written notice of revocation to BCBSND Member Services at the address listed on the back of my member ID card. 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.

Section F: Signature/Authorization

I understand this authorization is voluntary. I understand my treatment, payment, and enrollment in a health plan or eligibility for benefits is not conditioned on receiving this authorization.

I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Printed First Name	Printed Last Name
Signature	Today's Date (mm/dd/yyyy)

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Blue Cross Blue Shield of North Dakota
4510 13th Avenue South • Fargo, ND 58121

Blue Cross Blue Shield of North Dakota (BCBSND) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex. BCBSND does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, sexual orientation or sex. BCBSND:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, please call Member Services at 1-844-363-8457 (toll-free) or through the North Dakota Relay at 1-800-366-6888 or 711. If you believe BCBSND has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex, you can file a grievance with: Civil Rights Coordinator, 4510 13th Ave. S. Fargo, ND 58121, 701-297-1638 or North Dakota Relay at 800-366-6888 or 711, 701-282-1804 (fax), CivilRightsCoordinator@bcbsnd.com (email) (unencrypted emails present a risk.)

You can file a grievance in person or by mail, fax, or email within 180 days of the date of the alleged discrimination. Grievance forms are available at http://www.bcbsnd.com/report or by calling 1-844-363-8457. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave. S.W. Room 509F, HHH Building, Washington, DC 20201, 800-368-1019 or 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish) – ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. También hay disponibles ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles sin cargo. Llame al 1-844-363-8457 (TTY: 1-800-366-6888 o 711) o hable con su proveedor.

Deutsch (German) – ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen kostenfreie fremdsprachliche Unterstützung zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Rufen Sie 1-844-363-8457 (TTY: 1-800-366-6888 oder 711) an oder sprechen Sie mit Ihrem Anbieter.

中文 (Chinese) – 注意：如果您說中文，我們可以為您提供免費的語言協助服務。亦免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打 1-844-363-8457（聽障服務專線TTY：1-800-366-6888 或 711）或與您的醫療服務提供者討論。

Oromoo (Oromo) – XIYYEEFFANNOO: Afaan Oromoo dubbattu yoo ta'e, tajaajilli gargaarsa afaan hiikuu kaffaltii malee ni argama. Gargaarsi dabalataa gargaaraadhaaf tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. Bilbili 1-844-363-8457 (TTY: 1-800-366-6888 or 711) ykn dhiyeessaa kee waliin haasa'i.

Tiếng Việt (Vietnamese) – CHÚ Ý: Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận. Xin gọi 1-844-363-8457 (TTY: 1-800-366-6888 hoặc 711) hoặc nói chuyện với nhà cung cấp của quý vị.

Ikirundi (Bantu – Kirundi) – Wiyubare: Nimba uvuga Ikirundi, wemerewe ubufasha bwo kuronka ururimi ku buntu. Wemerewe kandi ubufasha bukwiye bw'inyongera na serivisi vyo gutanga amakuru mu buryo bworoshe ku buntu. Hamagara kuri 1-844-363-8457 (TTY: 1-800-366-6888 canke 711) canke uvugane n'ujejwe kugufasha.

العربية (Arabic) – تنبيه: إذا كنت تتحدث العربية، فتتوفر لك خدمات المساعدة اللغوية المجانية. تتوفر أيضًا وسائل وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات سهلة الاستخدام من دون أي تكلفة. اتصل على الرقم: 1-844-363-8457 (الهاتف النصي: 1-800-366-6888 أو 711) أو تحدث إلى مقدم الرعاية المتابع لك.

Kiswahili (Swahili) – ZINGATIA: Ikiwa unazungumza Kiswahili, huduma za msaada wa lugha bila malipo zinapatikana kwa ajili yako. Vifaa na huduma saidizi zinazofaa ili kutoa taarifa katika miundo inayoweza kufikiwa pia hupatikana bila malipo. Piga simu 1-844-363-8457 (TTY: 1-800-366-6888 au 711) au zungumza na mtoa huduma wako.

Русский (Russian) – ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах. Позвоните по телефону 1-844-363-8457 (TTY: 1-800-366-6888 или 711) или обратитесь к своему поставщику услуг.

日本語 (Japanese) – お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。情報を利用可能な形式で提供するための適切な補助具やサービスも無料でご利用いただけます。1-844-363-8457（TTY：1-800-366-6888 または 711）にお電話いただくか、医療提供者にご相談ください。

नेपाली (Nepali) – ध्यान दिनुहोस्: तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-844-363-8457 (TTY: 1-800-366-6888 वा 711) मा कल गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Français (French) – ATTENTION : Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés dans des formats accessibles. Appelez le 1-844-363-8457 (ATS : 1-800-366-6888 ou 711) ou adressez-vous à votre fournisseur.

한국어 (Korean) – 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하는 적절한 보조 수단 및 서비스도 무료로 이용하실 수 있습니다. 1-844-363-8457(TTY: 1-800-366-6888 또는 711)번으로 전화하거나 담당 의료 서비스 제공자와 상의하십시오.

Tagalog (Tagalog) – PAUNAWA: Kung nagsasalita kayo ng Tagalog, mayroong kayong magagamit na libreng tulong na mga serbisyo sa wika. Mayroon ding mga angkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format na makukuha ng walang singil. Tumawag sa 1-844-363-8457 (TTY: 1-800-366-6888 o 711) o makipag-usap sa iyong provider.

Norsk (Norwegian) – OBS: Hvis du snakker norsk, er gratis språkhjelp tilgjengelig for deg. Passende ytterligere hjelpemidler og tjenester for å oppgi informasjon i tilgjengelige formater er også tilgjengelig kostnadsfritt. Ring 1-844-363-8457 (TTY: 1-800-366-6888 eller 711) eller snakk med leverandøren din.

Diné (Navajo) – YÁ'ÁT'ÉÉH NITSÁHÁKEES: Díí Diné bizaad bee yáníłti'go, t'áá íiyisí t'áá bee yáhoot'éél dóó baa áháyá' át'é. T'áá jíík'ehígíí bee na'ách'ąą' holne' dóó t'áá shikaadéé' danilį́į́'ígíí t'áá jíík'ehgo bee hóló, dóó t'áá íiyisí doo béésh bee hadooleeł da. 1-844-363-8457 bee hojiij' (TTY: 1-800-366-6888 dóó 711), dóó naaltsoos nínízingo bee iiná bee nił hane'ígíí nihił ch'á hodool'į'.