Print Form

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Authorization for Disclosure of Protected Health Information

This authorization will permit Blue Cross and Blue Shield of Alabama and its business associate(s) on behalf of your Health Plan to disclose your health information that you describe below ("Protected Health Information") to the persons or entities and for the purpose that you describe below. **Please read and complete the following, and return to Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, PO Box 10485, Birmingham, Alabama 35202-0485.**

A. The Individual Who is The Subject of The Protected Health Information.

Note: A separate authorization form must be completed by each individual (or his/her personal representative) who desires to request that Blue Cross and Blue Shield of Alabama and its business associate(s) on behalf of his/her Health Plan disclose his/her Protected Health Information as described in this authorization.

Name	Date of Birth *(MMDDYYYY)*	Contract Number *(as it appears on your Health Plan ID Card)*	Social Security Number
Address			Telephone Number [ ] –

B. Description of My Protected Health Information To Be Disclosed.

Note: Please insert your initials in front of the paragraph below (1, 2 or 3) that applies to the description of your Protected Health Information to be disclosed pursuant to this authorization. If you initial paragraph 2 or 3, please complete the blanks below that paragraph.

1. _____ **Any or all of my Protected Health Information that may be requested from time to time by the person(s) I identify in Section D. below.**

2. _____ **All my Protected Health Information related to one or more of the following:**
   Description of Claim _____
   Time frame(s) of Service _____
   Name of Provider _____

3. _____ **Other. Here is a specific description of my Protected Health Information to be disclosed.**
   _____
   _____

C. Person(s) Authorized To Disclose My Protected Health Information.

By signing this authorization, I hereby authorize Blue Cross and Blue Shield of Alabama and its business associate(s) on behalf of my Health Plan (identified by the Contract Number above) to disclose my Protected Health Information.

D. Person(s) Authorized To Receive My Protected Health Information.

Name _____
Address _____
Telephone [ ] – _____

By signing this authorization, I understand that my Protected Health Information described herein may be redisclosed by the person(s) I have authorized to receive and use my Protected Health Information and that my Protected Health Information described herein may no longer be protected by federal privacy laws.

E. Purpose of This Disclosure of My Protected Health Information.

☐ **At my request** ☐ **Other (please specify)** _____

F. Date of Expiration of this Authorization.

☐ **Until my coverage under my Health Plan (identified by the Contract Number above) terminates.**

☐ **Expiration Date** _____

If no expiration date is indicated, this authorization will expire in 90 days from the date of this authorization.

(Continue on back)

G. Right to Revoke this Authorization.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed below. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before you received my written notice of revocation.

Blue Cross and Blue Shield of Alabama
Attention: Privacy Office
Post Office Box 2643
Birmingham, Alabama 35202-2643

H. Signature:

I, _____ , have had full opportunity to read and consider the contents of this authorization. I understand that my Health Plan will not condition its payment activities in connection with my claims, or my enrollment in my Health Plan, or my eligibility for benefits upon my giving this authorization.

Signature _____ **Date** _____

***Personal Representative Signature** _____ **Date** _____

*If signed as a Personal Representative, you must describe your authority to act as the Personal Representative of the individual who is the subject of the Protected Health Information described in this authorization ("Individual") **by initialing one of the following:**

_____ The Individual is an unemancipated minor child, I am the parent and have authority under applicable law to act on behalf of the Individual in making decisions related to health care, and the health information described herein is relevant to my personal representation of the Individual. ***Please Note: You should consult your state's laws to find out if you have legal authority to make health care decisions for your child. If you are unsure whether you have such legal authority, both you and your child must sign this authorization.***

_____ The Individual is an adult, unemancipated minor or emancipated minor, I am the guardian, attorney-in-fact or other authorized representative and have authority under applicable law to act on behalf of the Individual in making decisions related to health care, and the health information described herein is relevant to my personal representation of the Individual. ***Attached is a copy of the legal document(s) that give me authority to act as a Personal Representative, such as letters of guardianship.***

_____ The Individual is deceased, I am the executor, administrator or other person authorized under applicable law to act on behalf of the Individual's estate, and the health information described herein is relevant to my personal representation of the Individual or the Individual's estate. ***Attached is a copy of the legal document(s) that give me authority to act as a Personal Representative, such as letters testamentary or letters of administration.***

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS AFTER YOU SIGN IT.