Authorization for the Release of Protected Health Information (PHI)

BlueCross BlueShield of Kansas

There are times when you may want your PHI released to other individuals like a spouse, parent, guardian, or other family member. Because your records are confidential, we will need your signed consent to release your PHI. Release of PHI includes both written records and verbal information.

Parents/Guardians: We want to be able to speak with you on behalf of your dependent child (over the age of 18 or between the ages of 14-18 for certain diagnosis) about their PHI. In order to do this, we are required to have their written consent.

If you want to share your PHI with someone else, please complete all sections carefully and return to Blue Cross and Blue Shield of Kansas (BCBSKS). This form is available online at **bcbsks.com.**

Section 1 – Person Authorizing Release

First Name _____ Mailing Address _____

Last Name _____ City _____

Member Identification Number _____ State _____ ZIP Code _____ +4 _____

Date of Birth ____ / ____ / ____

Section 1a – Authorize Release

I authorize BCBSKS to release all information by all channels about eligibility, enrollment, underwriting, premiums, plan benefits, claims, correspondence to or from BCBSKS and prior authorization or determinations for services provided by any physician or hospital (excluding substance use disorder).
**Note - If your request pertains to Substance Use Disorder please refer to the Substance Use Disorder Authorization Form.*

☐ **Yes.** I understand this selection includes all policies (example: health, dental, cancer, and/or hospital indemnity policies) and all time periods (historical, current, and future dates). **Skip to Section 2 on page 2**

☐ **No. (Fill out the information Section 1b)**

Section 1b – Authorize Release

Pertaining to this time period (check one box):

☐ Any or all dates ☐ Range of dates

From: ____ / ____ / ____ (MM / DD / YYYY) to ____ / ____ / ____ (MM / DD / YYYY)

Specific date: ____ / ____ / ____ (MM / DD / YYYY)

I authorize BCBSKS to release (check one box):

☐ All information about eligibility, enrollment, underwriting, premiums, plan benefits, claims, correspondence to or from BCBSKS and prior authorization or determinations for services provided by any physician or hospital.

☐ Documents, records, and other information to appeal a BCBSKS decision regarding my claim. May include medical records from my health care providers (excluding psychotherapy notes and information regarding alcohol and substance abuse). Important: Submission of this form does not constitute an appeal.

This release of information is for the specific purpose of Assistance with: (check all boxes that apply)

☐ **All policies**

- ☐ All health policies
- ☐ All dental policies
- ☐ All cancer policies
- ☐ All hospital indemnity policies
- ☐ Or for the specific purpose of:

Section 2 – Release of Protected Health Information (PHI)

Release my PHI to the following people or categories of people:

First Name or Category (i.e., billing staff, medical staff)

RECORDS DEPOSITION SERVICE, INC
Last Name

PO BOX 5054, SOUTHFIELD, MI, 48086-5054
Organization Name

(248) 357 - 3330
Phone Number

____ / ____ / ____
Date of Birth

First Name or Category (i.e., billing staff, medical staff)

Last Name

Organization Name

(____) ____ - ____
Phone Number

____ / ____ / ____
Date of Birth

First Name or Category (i.e., billing staff, medical staff)

Last Name

Organization Name

(____) ____ - ____
Phone Number

____ / ____ / ____
Date of Birth

Dependent child authorization (under age 18):

☐ I authorize the release of PHI for my dependent(s) listed below:

Release my dependents' PHI to the following people or categories of people:

First Name or Category (i.e., billing staff, medical staff)

Last Name

Organization Name

(____) ____ - ____
Phone Number

____ / ____ / ____
Date of Birth

First Name or Category (i.e., billing staff, medical staff)

Last Name

Organization Name

(____) ____ - ____
Phone Number

____ / ____ / ____
Date of Birth

Section 3 – Authorization

I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations unless the information being disclosed is protected by federal alcohol and substance abuse regulation (FASAR). I understand that BCBSKS does not condition payment, enrollment, or eligibility for benefits on whether I sign this authorization. This authorization is valid until I no longer have coverage with BCBSKS, dependents reach the age of 18, or until such time as written revocation has been received by BCBSKS.

In addition, I understand that I may revoke this authorization at any time by notifying BCBSKS in writing and that revocation of this authorization will not affect any action taken in reliance of this authorization before the written revocation was received. **If signing authorization as Power of Attorney, Power of Attorney for Health Care or Guardian/Conservator, a copy of the legal document must accompany this form.**

Your signature required

Applicant

____ / ____ / ____
Date Signed

Print Name

When completed, please mail to:

Blue Cross and Blue Shield of Kansas
1133 SW Topeka Blvd., Topeka, KS 66629-0001

Note: Please keep a copy of this form for your files.

Internal Use Only

Return to _____

Mail stop _____