BlueCross of Northeastern Pennsylvania

Independent Licensee of the Blue Cross and Blue Shield Association
®Registered Mark of the Blue Cross and Blue Shield Association

Authorization Form

A signed authorization to disclose protected health information is required under federal rules implementing the Health Insurance Portability and Accountability Act (HIPAA).

Section A - Member Information (Individual whose information will be released):

Name: (Last, First, Middle Initial, Title [Sr., Jr., III.])	**Date of Birth:** / /	**Telephone Number:** (including Area Code)
Address: (including ZIP Code)		**Group Number:**

Member ID Number(s): (as shown on the member's identification card)

Section B – Authorized Person (person or organization receiving your information)

I authorize this health plan and its affiliates to disclose the above individual's protected health information to:
RECORDS DEPOSITION SERVICE, INC.
P.O. BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337
(You must include the name, address, and phone number of the person or organization receiving the member information)

Section C – Description of Information to be released: (type of information that will be used or disclosed).

1. Psychotherapy Notes: _____ (Initials) - Federal law requires a separate authorization to use or disclose psychotherapy notes. If you initial this line, you may not check any other box below.

2. Description of the Information to be Disclosed: (Type of information that will be released. Please check only that which applies)

☐ Payment Information ☐ Enrollment/Membership ☐ Pre-Cert / Referral Information
☐ Case Management Information ☐ Claims Information ☐ Pharmacy Information
☐ Disease Management ☐ Health Management ☐ Address/Contract Changes
☑ Other: PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST

3. Purpose of Disclosure: FOR DISCOVERY BEFORE TRIAL
Examples: At my request; Family member who assists with health insurance issues; Appeal information related to my claim on (date)

4. I understand that my specific authorization is needed to release my information pertaining to the items listed below. By initialing, I authorize release of the information pertinent to my case:
HIV/AIDS _____ (Initials) **Mental Health _____ (Initials)** **Substance Abuse _____ (Initials)**

Section D - Expiration and Revocation: (when this authorization will end)

Expiration: This authorization will expire on ____/____/____ or on the occurrence of the following event: (NOTE: The authorization form is valid only for two years unless you have indicated a date that occurs prior to the two-year expiration date.)

Right to Revoke: You may revoke this authorization at any time by contacting Blue Cross of Northeastern Pennsylvania. Your revocation of this authorization will not affect any action taken before receipt of your notice of revocation. (Please see reverse side for contact information.)

Section E - Personal Representative Information: Complete this section if a personal representative is authorizing disclosure of the member's information on behalf of the member. See the reverse side of this form for information and directions about personal representatives. A copy of a power of attorney or other court-initiated document will be required, if applicable.

Name: (Last, First, Middle Initial, Title [Sr., Jr., III.])	**Relationship to the Member:**
Address: (including ZIP Code)	**Telephone Number:** (including Area Code)

Section F- Signature/Date:

I understand the nature of this release. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits, or payment of claims.

Signature: _____ **Date:** _____

The member or member's personal representative must sign and date this form for it to be processed.