BlueCross BlueShield of Illinois

Standard Authorization Form to Release Protected Health Information (PHI)

Use this form to authorize Blue Cross and Blue Shield of Illinois (BCBSIL) to disclose your protected health information (PHI) to a specific person or entity. You may follow the instructions below or call the number listed on your Member ID card if you need help completing the form. You must complete the entire form.

Please note:

- One authorization form can be used for multiple services or providers or you can complete the form claim by claim, procedure by procedure, or for services provided during certain time periods.
- The use of the authorization form is voluntary.

Section I. Name and information of person whose PHI is being disclosed

Name ____________________ Date of Birth ____________________

Group Number ____________________ Identification/Subscriber Number ____________________ Social Security Number ____________________

Address ____________________ City ____________________

State ____________________ Zip Code ____________________ Area Code & Phone Number ____________________

The information in Section I applies to the person whose PHI is being disclosed. The person could be the policy holder, his or her spouse, a dependent or any other person covered under the policy or a person who has their own coverage.

Section II. Authorization and Purpose

I authorize BCBSIL to release my PHI to the person or organization listed below. I understand if the person or organization listed below is not a health plan or health care provider, the PHI may not be protected by federal privacy laws.

Persons/Organizations authorized to receive your information: RECORDS DEPOSITION SERVICE, INC.

Relationship: ____________________

Purpose: PRE TRIAL DISCOVERY

Address: PO BOX 5054

City: SOUTHFIELD

State: MI

Zip Code: 48086-5054

The information in Section II identifies the person or organization that will be receiving the PHI about the person named in Section I. A person that needs access to the PHI could be a family member, a close friend, a broker, or an attorney. If the person wants PHI to go to an organization, please include the area and/or job title of the person at the organization, for example, Benefits Representatives, Human Resources Department, Associate XYZ Insurance Agency, etc.

Section III. Description of Sensitive Protected Health Information (SPHI) and PHI to be Released

Complete Parts A and B of this section

A. Release of SPHI that may be protected under State Law. If you check "yes," you are authorizing BCBSIL to release the SPHI listed below and if applicable to your data release request, it will be included in the information you select in III.B. If you check "no" or make no selection at all, SPHI will not be released. This authorization may not be used for the release of Psychotherapy Notes.

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome,
- Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases),
- Drug, alcohol or substance abuse,
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions), and
- Genetic testing.

Yes ☐

No ☐

The information in Section III-A applies when a person wants specific SPHI as listed above to be released to their authorized representative, the person must specifically authorize that release.

B. Description of PHI to be released. You may select one or more.

			Dates of Services From:	To:
☐	Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).	________	________
☐	Claims Information:	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.).	________	________
☐	Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.	________	________
☐	Premium Information:	Includes information related to billing cycles, bank draft changes, etc.	________	________
☐	Services from Provider or Supplier:	Provider/Supplier Name: ________ Describe the exact information you want released:	________	________
X	Other: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST	Add other information that is not listed above.	________	________

Section III-B is where the person specifies what PHI they are authorizing BCBSIL to release.

Section IV. Expiration & Right to Revoke or Terminate the Authorization

Expiration: Select a date/event when authorization will expire. The authorization cannot be processed if this is left blank.

☐ One year from the date it is signed ☐ Other (insert date or event): ____________________

Right to Revoke/Terminate: You may end this authorization at any time by giving written notice to BCBSIL at the address listed below; however, BCBSIL is not responsible for the PHI released before the authorization was terminated.

In Section IV, the person must select a date when this authorization will end. All valid authorizations must contain a specific expiration date or event; for example: "hospitalization end date", "rehabilitation end date", etc. In addition, BCBSIL is providing information about the right to terminate an authorization at any time.

Section V. Signature & Acceptance of Terms.

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization.

Signature	Relationship	Date (MM-DD-YY)

Document must be signed by the person, the parent of a minor child or the person's authorized representative. If you are a parent signing on behalf of a minor child, please sign your name – not the child's name. This authorization will expire when the minor child turns 18 years of age, unless proof of legal guardianship is produced. If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and provide copies of the appropriate Legal documents. If these documents are already on file with BCBSIL, you do not need to provide.

Authorized Representative's Name ____________________ Relationship to Person ____________________

Authorized Representative's Address ____________________ City ____________________

State __________ Zip Code __________ Authorized Representative's Area Code & Phone Number ____________________

Before sending this form, make a copy for your records:

- Photocopy this signed authorization, or
- Complete and sign the duplicate authorization form

Mail the signed authorization to:

Blue Cross and Blue Shield of Illinois
PO Box 805107
Chicago, IL 60680-4112

If you need assistance completing the form, refer to the instructions above or call the number listed on your Member ID Card.