Louisiana HMO Louisiana

## AUTHORIZATION FOR THE USE / RELEASE OF PROTECTED HEALTH INFORMATION

Purpose: This form is used for an individual to authorize Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as "Blue Cross") to use or disclose the individual's protected health information for the purposes stated.

Instructions: Items with an "*" are required to be completed. If this authorization is for the release of psychotherapy notes, genetic information, or any information related to a member's alcohol or drug use disorder records, please check the appropriate box in Section B. The form must be signed and dated.

**SECTION A: Member Information.**

*Name _____

*Address _____

Telephone _____ E-mail _____

*Member Number _____ Or Social Security Number _____

**Please read the following and complete the information requested.**

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan or eligibility for benefits on receiving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

**SECTION B: The use and/or disclosure of information being authorized.**

***Purpose: Please describe the purpose or reason for the use and/or disclosure in the blanks below.**

_____

_____

***Protected Health Information to Be Used and/or Disclosed: Specifically and meaningfully describe the protected health information that this authorization will allow to be used and/or disclosed including how much and what kind of information.**

_____

_____

_____

☐ Check if this authorization is for genetic information.
☐ Check if this authorization is for psychotherapy notes.
☐ Check if this authorization is for alcohol or drug use disorder records.

**Please Note:**
If this authorization is for psychotherapy notes, it must not be used as an authorization for any other type of protected health information.

If this authorization is for alcohol or drug use records, the following written statement will be included with the disclosure made by Blue Cross: *Federal regulation 42 CFR part 2 prohibits unauthorized disclosure of these records.*

**SECTION C: Entities allowed to disclose and use/receive information.**

Entities Authorized to Disclose/Release: Name or specifically describe the persons and/or organizations, including Blue Cross, who will be authorized to disclose/release the protected health information described above.

Person/Organization #1 Person/Organization #2

*Name _____ *Name _____

*Address _____ *Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Entities Authorized to Receive and Use: Name the persons and/or organizations, including Blue Cross, whom this authorization will allow to receive and/or use the protected health information described above.

Person/Organization #1 Person/Organization #2

*Name _____ *Name _____

*Organization RECORDS DEPOSITION SERVICE, INC. *Organization _____

*Address 120 W. MADISON ST., SUITE 300 *Address _____

City CHICAGO State IL Zip 60602 City _____ State _____ Zip _____

If the organization is not your treating provider, you must also list the name of the individual who is authorized to receive your information at the organization. If this authorization is for alcohol or drug use disorder records and you do not list a name, Blue Cross cannot release the information.

**SECTION D: Expiration and revocation.**

*Expiration: This authorization will expire (complete one):

☐ On ____/____/____ (MM/DD/YYYY)

☐ On occurrence of the following event or condition (which must relate to the individual or to the purpose of the use and/or disclosure being authorized and last no longer than reasonably necessary to serve the purpose).

_____

_____

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the Privacy Office at Blue Cross, P.O. Box 98029, Baton Rouge, LA 70898-9029. Verbal notice of revocation is permissible for alcohol or drug use disorder records by calling the phone number on the back of the member identification card. Revocation of this authorization will *not* affect any action we took in reliance on this authorization before we received your notice of revocation.

**SECTION E: Individual's Signature.**

You are entitled to a copy of this authorization after you sign it.

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.

*Signature: _____ *Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Note to department requesting/receiving authorization: Documentation requirement. Include this authorization in your department files and maintain in hard copy or electronically for 10 years after the last effective date.