AUTHORIZATION TO RELEASE INFORMATION

Section A: Member information (person granting release of information)

Member name: _____

Address: _____

Telephone: (_____)_____ Blue MedicareRx[SM] (PDP) Member ID 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 or payment for benefits on receiving this authorization.

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

Psychotherapy Notes: Federal law says that Psychotherapy notes cannot be released using the same authorization form as other records. In order to release Psychotherapy notes, you need to fill out a separate authorization form.

Purpose of release of information: The PHI described below may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, administration of my Blue MedicareRx benefits, or other purposes as I may direct.

Section B: I authorize Blue Cross and Blue Shield of Arizona to release the following information:

(Check one or more box(es) and fill in the blanks, if applicable. Specifically and meaningfully describe your PHI that you are allowing to be disclosed.)

I SPECIFICALLY AUTHORIZE the release of my Protected Health Information consistent with the description above. (If the information relates to diagnosis or treatment of alcoholism or drug dependency, you must provide the name of the treatment facilities or program(s).)

☐ Address, date of birth, membership status

☐ Claim information for service with (provider name) _____ for dates of service from _____ to _____

☐ Premium information

☐ Psychotherapy notes (see information above)

☐ Information necessary to help me understand my benefits and resolve billing issues, benefits disputes, and other matters.

☑ Other: (specify the information and types of information to be released):
PLEASE SEE THE ATTACHED SUBPOENA OR LETTER REQUEST FOR THE INFORMATION TO BE DISCLOSED

_____

Section C: If this release involves a claim or an appeal, select where your claim notices and member payments are sent: (leave blank if this does not apply to you)

☐ I want all claim notices, appeal-related correspondence and member payments for these claims sent to the person I have named below. I understand that by checking this box, the information will not be sent to the address in my membership record.

☐ I do not want all claim notices, appeal-related correspondence and member payments for these claims sent to the person named below. These will be sent to the address in my membership record.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION

Section D: Persons or organizations authorized to receive and use my Protected Health Information:

☑ Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations) you are allowing to receive and use the PHI described above:

RECORDS DEPOSITION SERVICE, INC. P: 248-357-3330 F: 248-357-3337

Name or Title within Organization Phone Number

P.O. BOX 5054, SOUTHFIELD, MICHIGAN 48086-5054

Address (Street, City, State, ZIP code)

☐ This person is my authorized representative.

☑ Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) you are allowing to disclose the PHI described above (check at least one box and fill in the blank, if applicable):

☑ Blue Cross Blue Shield of Arizona

☐ Other persons/organizations:

_____

_____

Briefly describe the purpose of the disclosure: LEGAL - FOR DISCOVERY BEFORE TRIAL

_____

Section E: Expiration and revocation

Expiration: This authorization will expire one year from the date the authorization is signed or check a box and complete the blanks, as applicable:

☐ On (insert date) _____ / _____ / _____

☐ When a particular matter is resolved (specify the matter, for example, "Claim for February 2011 prescriptions"):_____

☐ When my Blue MedicareRx coverage is terminated.

Right to Revoke: I understand that I may cancel this authorization in writing at any time, but it will not affect any release of any information processed before I cancel it. Written cancellation notices should be sent to the address on the back of this form.

Section F: Signature

If the information relates to diagnosis or treatment of alcoholism or drug dependency, I understand that the person(s) I have named to receive the information must treat it as confidential. The information cannot be disclosed again without another signed authorization from me. For all information other than diagnosis or treatment of alcoholism or drug dependency, I understand that the person(s) I have named to receive information may not be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect 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 an authorized representative, complete the following:

Authorized Representative's Name:

_____

Relationship to Individual:

_____

(An Authorized Representative must provide documentation of legal status, such as Power of Attorney.)