BlueCross BlueShield of Nebraska An Independent Licensee of the Blue Cross and Blue Shield Association P.O. Box 247040 • Omaha, NE 68124	ID: Sub. Last Name:
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION	Acronym: AUT HAUT blue cross and blue shield of nebraska office use only
This form authorizes Blue Cross and Blue Shield of Nebraska (BCBSNE	) to release your Protected Health Information. You only need to c

This form authorizes Blue Cross and Blue Shield of Nebraska (BCBSNE) to release your Protected Health Information. You only need to complete this form if you want BCBSNE to give your Protected Health Information to another person or organization, such as your spouse. "Protected Health Information" (PHI) is information about you that may identify you and relates to your past, present or future physical or mental health or condition and related health services. Please print clearly in blue or black ink.

## SECTION A: Individual authorizing release of PHI

YOUR NAME					
YOUR TELEPHONI NUMBER: (Day)	E	_ (Evening)	ALPHA PREFIX)	– (NUMBERS) –	(If applicable)
YOUR ADDRESS:	Street			Apartment #	
	City		State	ZIP Code	

### **SECTION B: Description of authorization**

I hereby authorize Blue Cross and Blue Shield of Nebraska (BCBSNE) to release my Protected Health Information (PHI) as described in this authorization. I understand that my PHI may include, but is not limited to, the following: medical records, emergency care records, billing statements, Explanation of Benefits, diagnostic imaging reports, transcribed hospital reports, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization.

I further understand that my PHI may include information related to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/AIDS, prescription medication, pregnancy/maternity, organ transplants, and chemical dependency (including alcohol and drug treatment).

I further understand that this authorization applies to ALL PHI, except for the following limitations (if none, please leave blank):

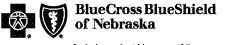
#### SECTION C: Persons/Organizations authorized to receive my PHI

Please tell us who you are authorizing to receive your PHI by completing the table below.

- For "Person's Relationship To You" please give a general description such as "husband" or "attorney."
- The "Start Date" is the date this authorization will begin.
- The "End Date" is the date this authorization will end. If you do not want this authorization to end on a specific date, please check the "Upon Disenrollment" box. If you leave both the "End Date" AND "Upon Disenrollment" boxes blank, this authorization will remain valid until your disenrollment from your health plan or your death. If your coverage is already terminated you MUST provide us with a future "End Date".

Name of Person to Receive PHI	Person's Relationship To You	Address	ZIP Code	Telephone Number	Start Date	End Date	Upon Disenrollmen
RECORDS DEPOSITION SERVICE, INC.	AGENT FOR ATTORNEY	PO BOX 5054 SOUTHFIELD, MI	48086 -5054	P: 248-357 -3330 F: 248-357 -3337			

### Individuals Authorized to Receive Your PHI



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P.O. Box 247040 • Omaha, NE 68124

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

BLUE CROSS AND BLUE SHIELD OF NEBRASKA OFFICE USE ONLY

Purpose for which release is to be made (NOTE: you are not required to provide a specific purpose; if left blank, BCBSNE will presume that the release is simply being made at your request): FOR DISCOVERY BEFORE TRIAL

### SECTION D: Terms and conditions of this authorization

I understand that I may refuse to sign this authorization. I understand that BCBSNE may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I also understand that if the person(s)/organization(s) authorized to receive my PHI is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I further understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization (please contact BCBSNE at the address or telephone number listed below to obtain the standard authorization revocation form). Unless revoked earlier, this authorization will end on the date specified above or upon my disenrollment from the health plan.

# SECTION E: Your signature

Signature of Individual:

Date:

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

Personal Representative's Name:

Relationship to the member (check one of the following):

- □ Parent. As the parent of the minor child you are authorized to obtain protected health information (PHI). If you want to authorize another person to receive PHI on this minor child you will need to check this box and write your name in the personal representative field above.
- Legal Guardian, Conservator or Executor. Please attach legal documentation showing that you are the legal guardian, conservator or executor.
- Power of Attorney. Please attach legal documentation showing that you hold a power of attorney. If you hold a Health Care Power of Attorney it must be accompanied by a Doctor's certification of incapacity.

Please return completed and signed form to the following address: Blue Cross and Blue Shield of Nebraska Attention: Privacy Office P.O. Box 247040 Omaha, NE 68124 FAX Number: (402) 392-4153

If you have questions, need additional information or assistance in completing this form, please contact us at the above address or (402) 343-3521 or Toll Free (877) 258-3999