

# Authorization Form

For the release of Protected Health Information to other individuals - **Please complete all three sections**



Section 1

Name of person authorizing release \_\_\_\_\_  
First Last

Address \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Street City State MM DD YYYY

ID Card No. \_\_\_\_\_

**Please release my Protected Health Information (PHI) to the following people only:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship \_\_\_\_\_  
First Last MM DD YYYY

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City State

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship \_\_\_\_\_  
First Last MM DD YYYY

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City State

This release of information is for the specific purpose of (check one box):

assisting me with my health plan     other (be specific) \_\_\_\_\_

Section 2

**Please check one of the following three scenarios.** If a box is **NOT** specifically marked, the named person on this form will be authorized to all PHI.

I authorize release of all information including eligibility, enrollment, underwriting, premiums, plan benefits, claims, and any correspondence to or from BCBSKS and prior authorization or determinations for services provided by any or all physicians and/or hospitals OR ONLY: \_\_\_\_\_  
Physician or Hospital Name  
*(Strike any category of information listed above that you do not want released.)*

I authorize release of all documents, records, and other information (excluding psychotherapy notes) from any or all physicians and/or hospitals OR ONLY: \_\_\_\_\_ for  
Physician or Hospital Name  
services from any dates OR ONLY: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ ; (including certain information subject to 42 C.F.R. Part 2 for alcohol and substance abuse.)

I am in the process of appealing the BCBSKS decision regarding my claim. Please disclose all documents, records, and other information used to make a determination related to the payment or denial of a claim for date of service on \_\_\_\_/\_\_\_\_/\_\_\_\_ by provider \_\_\_\_\_ which may include the medical records of my health care providers (excluding psychotherapy notes) and certain information subject to 42 C.F.R. Part 2 for alcohol and substance abuse. **(Important: Submission of this form does not constitute an appeal.)**

Section 3

I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. I understand that BCBSKS does not condition payment, enrollment, or eligibility for benefits on whether I sign this authorization. This authorization is valid until the termination of my health coverage with BCBSKS or until such time as written revocation has been received by BCBSKS. In addition, I understand that I may revoke this authorization at any time by notifying BCBSKS in writing and that revocation of this authorization will not affect any action taken in reliance of this authorization before the written revocation was received. **If signing authorization as Power of Attorney, Power of Attorney for Health Care or Guardian/Conservator, a copy of the legal document must accompany this form.**

**Your signature required** \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**When completed, please mail to:**

Blue Cross and Blue Shield of Kansas  
1133 SW Topeka Blvd., Topeka, KS 66629-0001

**Note:** Please keep a copy of this form for your files.

**Internal Use Only**

Return to \_\_\_\_\_

Mail stop \_\_\_\_\_