

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 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) _____

Please check one of the following three scenarios:

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.)

Section 2

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 _____