

Authorization for Release of Protected Health Information (PHI) Form



There are times when you may want your PHI released to other individuals like a spouse, parent, guardian or other family member. Because your records are confidential, we will need your signed consent to release your PHI. Release of PHI includes both written records and verbal information.

Parents/Guardians: We want to be able to speak with you on behalf of your dependent child (over the age of 18) about their PHI. In order to do this, we are required to have their written consent.

If you want to share your PHI with someone else, please complete all sections carefully and return to Blue Cross and Blue Shield of Kansas (BCBSKS). This form is available online at www.bcbsks.com.

Section 1

Person authorizing release

First Name _____

Street Address _____

Last Name _____

City _____

Member Identification Number _____

State _____ ZIP Code _____ +4 _____ Date of Birth (MM/DD/YYYY) _____

I authorize release of (check one box):

All information about eligibility, enrollment, underwriting, premiums, plan benefits, claims, correspondence to or from BCBSKS and prior authorization or determinations for services provided by any physician or hospital.

All documents, records, and other information (excluding psychotherapy notes) from any physician or hospital including information regarding alcohol and substance abuse.

Documents, records, and other information to appeal a BCBSKS decision regarding my claim. May include medical records from my health care providers (excluding psychotherapy notes) and information regarding alcohol and substance abuse.*

All documents, records, and other information from the following providers only:

Pertaining to this time period (check one box):

Any or all dates

Range of dates

From _____ to _____
MM DD YYYY MM DD YYYY

Specific date _____
MM DD YYYY

Release my information to (check one box):

Individuals listed below in Section 2

All providers and hospitals

The following providers and hospitals only:

*Important: Submission of this form does not constitute an appeal.

Section 2

Please release my PHI to the following people:

First Name _____

Last Name _____

Relationship _____ Phone _____

Please continue on the back. Your signature is required.

Section 2 Continued

Please release my PHI to the following people:

First Name _____ Last Name _____

Relationship _____ Phone _____

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

Assisting me with my health plan Other (be specific) _____

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 MM DD YYYY

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 _____