BlueCross BlueShield of Illinois

Instructions for Completing Standard Authorization Form

To Complete Form go to Page 4 of 5

This form should be used when authorizing Blue Cross Blue Shield of Illinois (BCBSIL) to disclose an individual's protected health information (PHI) to a specific person or entity. You can follow the instructions provided below or you can call Customer Service at the number listed on your Membership Identification card for assistance. **You must complete all the fields on this form.**

One **Authorization form** can be completed for multiple services and/or providers, but also claim by claim or procedure by procedure within a specified time period. The use of the **Authorization form** is voluntary and can be revoked at any time.

Section I:
*The purpose of this **section** is to identify the individual who is requesting the authorization. This individual could be the subscriber, their spouse, a dependent or any other **individual** covered under the subscriber's policy. All fields are **required**. Example: Jane Doe is the individual requesting the authorization.*

Section I. Name of Individual whose PHI is being released

Jane Doe		05-10-1962
Name		**Date of Birth**
123456	**XOP123456789**	**###-##-####**
Group #	**Identification/Subscriber #**	**Social Security Number**

123 Main Street	Anytown	IL	12345
Address	**City**	**State**	**ZIP**

312-555-1212
Area Code & Telephone Number

Section II:
The purpose of this section is to identify the individual or entity (a family member, close friend, broker, attorney, another trusted party, or organization) that the member named in Section I authorizes to have access to their PHI. If an organization is listed, please identify the name or job title of the person who can receive the PHI, i.e., Benefits Representative, Human Resources Department, XYZ Insurance Agency, etc. Example: Jane has identified Suzy Smith, her daughter as the person who can receive her PHI.

Section II. Name of Individual or Organization who is receiving PHI

I request and authorize Blue Cross and Blue Shield of Illinois to disclose my PHI for the purposes described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Suzy Smith	Daughter	Assisting in medical care
Persons/Organizations authorized to receive your information	**Relationship**	**Purpose**

456 Mill Road	Happytown	IL	45678
Address	**City**	**State**	**ZIP**

Section III. Description of PHI being Released *(This Authorization CANNOT be used to disclose Psychotherapy Notes)*

***Section III**:*
The purpose of this section is for the individual identified in Section I to select what PHI and in what form do they want released to the person/entity listed in Section II. Section III has 2 parts – both parts must be completed.

***Section III A**. The purpose of III A. is for the individual identified in Section I to authorize whether they want certain health information that may have additional protections under state law to be released to the individual/entity listed in Section 11. You must select either "**Yes**" or "**No.**" Example: Jane has authorized Suzy to receive her health information that may have additional protections under state law.*

Section III A. Release of Health Information protected under State Law

You must check "yes" or "no" if you authorize the release of medical information, test results, records, or communications specific to ***(note: "yes" means this information is included in the categories you designate in Part B below)***:

Health Information protected under State Law includes:

- Certain Communicable diseases (i.e., Human Immunodeficiency Virus, Sexually Transmitted Diseases and Hepatitis, etc.), Substance Abuse (Drug or Alcohol), Mental Health and Genetic Testing.

Yes ☒

No ☐

Section III B*. The purpose of this section is for the individual identified in Section I to list the specific types of PHI, BCBSIL can release to the authorized individual identified in Section II. The dates of services must be identified so BCBSIL only releases the information that is being requested. Example: Jane is authorizing BCBSIL to disclose claims information to Suzy for health care services provided from June 12, 2020, through March 30, 2022.*

Section III B. Release of Protected Health Information *(check one or more)*

			Dates of Services From:	To:
☐	Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).		
☒	Claims Information:	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.).	6-12-20	03-30-22
☐	Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.		
☐	Premium	Includes information related to billing cycles, bank draft changes, etc.		
☐	Services from (provider or supplier):	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier.)		
☐	Other:	_____ (Specify other information that is not listed in one of the categories above.)		

Section IV. Expiration and Revocation

Section IV*: The purpose of this section is for the individual identified in Section I to provide an expiration date of this authorization form and to acknowledge their right to revoke and terminate the Authorization at any time. All authorizations must contain a specific expiration date or expiration event (e.g., "**hospitalization end date**" or "**rehabilitation end date**," etc.). Example: Jane's authorization will remain valid for one year from the date she signed it or until Jane revokes the authorization.*

Expiration: This authorization will expire on (must choose one):

☒ One year from the date it is signed ☐ Other (insert date or event): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before the receipt of my written notice of revocation.**

V. Signature

Section V*: The purpose of this section is for the individual identified in Section I to sign and date the Authorization. However, if the authorization is being completed by the individual's personal representative identified below; the personal representative must provide documentation as described below. If the individual is a minor dependent under the age of 18, a parent or guardian may sign the authorization form. This form must be signed by the Individual, parent of minor child, or the Individuals person representative. Example: Jane signs and dates the form.*

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization

will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Jane Doe _____ 03-30-22 _____

Signature **Date: month/day/year**

If you are a Power of Attorney, Legal Guardian, Executor or Administrator completing this form, please complete the following and attach a copy of the legal documents that grant you this authority. Note: if these documents are already on file with BCBSIL, you do not need to attach a copy.

Personal Representative's Name **Relationship to Individual**

Personal Representative's Address **City** **State** **ZIP**

Personal Representative's Area Code & Telephone Number

Final Section: *The purpose of this section is to offer suggestions on how to keep a copy of the authorization before you submit to BCBSIL.*

BEFORE SENDING AUTHORIZATION FORM
YOU SHOULD KEEP A COPY FOR YOUR RECORDS
BY EITHER:

(1) MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR
(2) COMPLETING AND SIGNING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

BlueCross BlueShield of Illinois

Standard Authorization Form To Use or Disclose Protected Health Information (PHI)

I. Name of Individual whose PHI is being released

Name		Date of Birth
Group #	Identification/Subscriber #	Social Security Number

Address	City	State	ZIP

Area Code & Telephone Number

II. Name of Individual or Organization who is receiving PHI

I request and authorize Blue Cross and Blue Shield of Illinois to disclose my PHI for the purpose described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Persons/Organizations authorized to receive your information	Relationship	Purpose	
Address	City	State	ZIP

III. Description of PHI being Released (*This Authorization CANNOT be used to disclose Psychotherapy Notes*)

A. Release of Health Information protected under State Law

You must check "yes" or "no" if you authorize the release of medical information, test results, records or communications specific to ***(note: "yes" means this information is included in the categories you designate in Part B below)***:

Health Information protected under State Law includes:

- Certain Communicable diseases (Human Immunodeficiency Virus, Sexually Transmitted Diseases and Hepatitis, etc.), Substance Abuse (Drug or Alcohol), Mental Health and Genetic Testing.

Yes ☐

No ☐

B. Release of Protected Health Information *(check one or more)*

			Dates of Services From:	To:
☐	Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).		
☐	Claims	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.).		
☐	Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.		
☐	Premium	Includes information related to billing cycles, bank draft changes, etc.		
☐	Services from (provider or supplier):	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier.)		
☐	Other:	_____ (Specify other information that is not listed in one of the categories above.)		

IV. Expiration and Revocation:

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed ☐ Other (insert date or event): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

Signature **Date: month/day/year**

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of these documents if they are already on file with Blue Cross and Blue Shield of Illinois:

_____ _____

Personal Representative's Name **Relationship to Individual**

_____ _____ _____ _____

Personal Representative's Address **City** **State** **ZIP**

_____

Personal Representative's Area Code & Telephone Number

BEFORE RETURNING THIS FORM YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:

(1) MAKING A PHOTOCOPY OF THE SIGNED AUTHORIZATION; OR
(2) COMPLETING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

Mail your completed signed authorization to:
Blue Cross and Blue Shield of Illinois
P.O. Box 660044
Dallas, TX 75266-0044

If you need assistance completing the form, please refer to the instructions above or contact the Customer Service number listed on your Member Identification Card.

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the HCSC Privacy Office.

BlueCross BlueShield of Illinois

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká ánánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.