Member Authorization Form

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

PART A: MEMBER INFORMATION

Member last name	Member first name	Middle initial	Member date of birth

Member street address	City	State	ZIP code

Daytime telephone number (with area code)	Identification number (see identification card)	Group number (see identification card)

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please check each box that applies and enter first and last name.

☐ **My spouse** (enter first and last name)	☐ **My parents** (if you are over 18 - enter first and last name[s])
☐ **My domestic partner** (enter first and last name)	☐ **My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
☐ **My adult children** (enter first and last name[s])	☒ **Other** (enter first and last name [if you have it], name of company, and how it's related to you) RECORDS DEPOSITION SERVICE,INC. P.O. BOX 5054, SOUTHFIELD, MI 48086-5054 P:248-357-3330 F:248-357-3337

PART C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be used or released by Blue Cross and Blue Shield of Georgia on my behalf (check only one box):

☐ **All my information.** This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ **Only limited information** may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Doctor and hospital
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other: _____

I also approve the release of the following types of sensitive information by Blue Cross and Blue Shield of Georgia (check all boxes that apply to you):

☐ **All sensitive information**

OR

☐ **Just information about topics checked below**

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance abuse **
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

** I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described below in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

PART D: PURPOSE OF THIS APPROVAL

☐ To give out the information as shown on this form

OR

☐ For this reason(s): _____

PART E: DATE YOUR APPROVAL EXPIRES

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

☐ One year from the signature date in Part F

OR

☐ Earlier than one year and upon the date, event or condition described below

_____

PART F: REVIEW AND APPROVAL

I have read the contents of this form. I understand, agree, and allow Blue Cross and Blue Shield of Georgia to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Blue Cross and Blue Shield of Georgia does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Blue Cross and Blue Shield of Georgia. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature	Date
X	

DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)		Legal relationship to member	
Legal representative street address	City	State	ZIP code
Signature **X**			Date

Please return the completed form to:
Blue Cross and Blue Shield of Georgia

Be sure to keep a copy of this form for your records.

FOR RECIPIENT OF SUBSTANCE ABUSE INFORMATION

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For internal use only:	Inquiry tracking number