BlueCross BlueShield of Minnesota
An independent licensee of the Blue Cross and Blue Shield Association

Member Requested Authorization for Release of Information

Member Information (person granting release of information)

Member Name _____ Member ID _____

Date of Birth ___-___-_____ Group Number _____

I authorize Blue Cross to release the following information:

- ☐ Address, date of birth, membership status
- ☐ Claim Information for service with (provider name) _____ for dates of service from _____ to _____
- ☐ Premium Information
- ☐ Appeal Information
- ☐ Other

Note: Federal law says that Psychotherapy notes cannot be released using the same authorization form as other records. In order to release Psychotherapy notes, you need to fill out a separate authorization form.

- ☐ Psychotherapy notes

If this release involves a claim or an appeal, select where your claim notices and member payments are sent:

- ☐ I want Blue Cross to send all claim notices and member payments for these claims to the person I have named below. I understand that by checking this box, this information will **not** be sent to the address in my membership record.
- ☐ I do not want Blue Cross to send all claim notices and member payments for these claims to the person I have named below. These will be sent to the address in my membership record.

Blue Cross may release this information to:

Name **RECORDS DEPOSITION SERVICE, INC.**
Address **PO BOX 5054**
SOUTHFIELD, MI 48086 - 5054

Phone Number **248.357.3330** **FAX: 248.357.3337**

- ☐ This person is my Authorized Representative

Purpose for this Release

- ☐ Request of member or personal representative
- ☐ For my Authorized Representative to handle my appeal concerning the claim information listed above.

Note: I understand that this authorization does not constitute an assignment of benefits.

- ☒ Other, please specify **FOR DISCOVERY BEFORE TRIAL**

If the information relates to diagnosis or treatment of alcoholism or drug dependency, we must have the name of the treatment facilities or program(s):

_____

If the information relates to diagnosis or treatment of alcoholism or drug dependency, I understand that the person(s) I have named to receive the information must treat it as confidential. The information cannot be disclosed again without another signed authorization from me. For all information other than diagnosis or treatment of alcoholism or drug dependency, I understand that the person(s) I have named to receive information may not be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect it.

Right to Revoke - I understand that I may cancel this authorization in writing at any time, but it will not affect any release of any information processed before I cancel it.

_____ ___-___-_____
Signature of Member Date

_____ ___-___-_____
Signature of Parent or Personal Representative/Relationship to Member Date

This authorization is valid for one year after the date it is signed, unless an earlier expiration date is indicated here:

___-___-_____

Note: You have a right to keep a copy of this notice after you sign it.

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Please read these instructions carefully before completing this form.

When to Use This Form

Complete this form if you want Blue Cross to give information about you to someone else (e.g., an agent or family member). You must also use this form if you want someone to act on your behalf to question a claim or appeal a benefit decision.

Parents or a legal guardian may sign for a minor unless the minor is permitted under state law to consent to the treatment. In that case, the minor must sign the authorization.

How to Complete This Form

The Authorization for Release of Information form must be completed and signed by one of the following:

- The person whose information will be released
- The parent or legal guardian of a minor whose information will be released except as noted above
- The personal representative of the person whose information will be released (e.g., power of attorney, conservator, executor)

To complete this form:

- Fill in the name, member identification and date of birth of the person whose information will be released
- Check the type(s) of information you want us to release
- Decide if you want us to send your claim notices and any member payment for the claims to the person
- Fill in the name and address of the person or group who will receive the information
- State the purpose for this authorization unless it is at the request of the member or the member's personal representative
- Sign and date the form
- If you are not the person whose record will be released, state your relationship to that person

Mail or fax this form to

Blue Cross and Blue Shield of Minnesota
P.O. Box 64560
St. Paul MN 55164-0560
Fax: 651-662-7933

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