BlueCross BlueShield
of North Carolina

Member's Authorization Request Form

Commercial Operations / IDC

You may give Blue Cross and Blue Shield of North Carolina (Blue Cross NC) written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below.

Parents/Guardians: We want to be able to speak with you on behalf of your dependent child (over the age of 18 or between the ages of 14-18 for certain diagnosis) about their PHI. In order to do this, we are required to have their consent by completion of this form.

MEMBER WHOSE INFORMATION WILL BE DISCLOSED:

Member First Name: ______ M.I. ______ Member Last Name: ______

MEMBER'S DATE OF BIRTH ☐☐ / ☐☐ / ☐☐☐☐ (MONTH DAY YEAR)

SUBSCRIBER ID NUMBER (FROM YOUR ID CARD) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

The purpose of this disclosure is:

☐ to assist me with my health plan ☐ to coordinate and manage my health care ☑ Other LEGAL - DISCOVERY BEFORE TRIAL

At my request, I authorize Blue Cross NC to disclose Protected Health Information to (If you choose, you may designate more than one person. However, you must fill out one form per person.):

RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054, SOUTHFIELD, MI 48086-5054
P: 248-357-3330 F: 248-357-3337

RELATIONSHIP TO MEMBER: AGENT FOR ATTORNEY

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: (i) your subscriber ID number, (ii) your date of birth, and (iii) subscriber address.

I authorize Blue Cross NC to disclose the following PHI to the person/entity listed above. CHECK ONLY BOXES THAT APPLY:

☐ ALL Information Requested ☐ Premium Payment Information
☐ Enrollment Information ☐ Explanation of Benefits (EOB) Information
☐ Benefit Information ☐ All Claims Information

☐ All Services from a Specific Health Care Provider(s) (List Provider's Name): ______

☐ Other (Please List Specific PHI and/or Date Ranges): ______

If applicable, this information may contain sensitive data, including data related to treatment of sexually transmitted or communicable diseases, HIV/AIDS, mental and behavioral health (except psychotherapy notes), genetic testing and termination of pregnancy.

If applicable, I authorize Blue Cross NC to release alcohol/substance abuse information related to the above request. ☐ **Yes** ☐ **No**

I want the designated person/entity to have access to my PHI until my policy expires OR until the specified date of: ☐☐ / ☐☐ / ☐☐☐☐ (MONTH DAY YEAR)

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Note: This authorization will become effective on the date Blue Cross NC enters this authorization into its business system, typically five (5) days following receipt. If you want this authorization to <u>become effective</u> on a later date, please insert the date here: → __ __ / __ __ / __ __ __ __
MONTH DAY YEAR

I would like this authorization to expire on (enter date): → __ __ / __ __ / __ __ __ __
MONTH DAY YEAR

OR

☐ **WHEN MY COVERAGE EXPIRES**

(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt.)

I understand that I may revoke this authorization at any time by giving Blue Cross NC written notice mailed to the address below. I also understand that the revocation will not affect any action Blue Cross NC took in reliance on this authorization before Blue Cross NC received my written notice of revocation.

I also understand that this authorization will not affect the provision of or payment for my health plan benefits.

I also understand that if the persons or entities I authorize to receive my PHI are not subject to the Health Insurance Portability and Accountability Act ("HIPAA") or other federal health information privacy laws, they may re-disclose the PHI and it may no longer be protected by HIPAA.

However, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

Signature: ______________________ TODAY'S DATE __ __ / __ __ / __ __ __ __
MONTH DAY YEAR

If signed by an Individual Other than the Member (Print your Full Name): ______________________

Describe your authority to act for the member (e.g., power of attorney, court order, parent of minor child, etc.): ______________________

NOTE: Please attach the legal document naming you as the personal representative if you have not previously submitted it to us.

Return this authorization to:

Commercial Operations / IDC
Blue Cross and Blue Shield of North Carolina
PO Box 2291
Durham, NC 27702-2291

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