BlueCross BlueShield of Tennessee

www.bcbst.com

MEDICAL AUTHORIZATION

The Member's Information: Insert information about the individual whose information will be released.

Member Name: _____ Member ID Number: _____

Member Address: _____ Member Date of Birth: _____

_____ Member Social Security No.: _____

Employee Name (if different from member):

Who Can Release and Receive the Information: Insert the person/company who is allowed to release the information and the person/company who is allowed to receive the information.

The following person/company is allowed to release the information as requested: _____

BLUE CROSS BLUE SHIELD OF TENNESSEE

The information can be provided to (include address): **RECORDS DEPOSITION SERVICE, INC. PO BOX 5054, SOUTHFIELD, MI 48086-5054**

P: 248-357-3330 F: 248-357-3337

What Information is Being Released: Insert what information you are authorizing to be released. Describe in detail the kind of information (e.g. claims information, premium information, medical records, etc.) you want released and if applicable, the date(s) of the information (e.g. claims for the last 6 months, premium payment record for January, etc.).

Please see enclosed Subpoena or Letter Request for information to be disclosed.

In addition, if you agree that the following types of information may be released, please indicate so by checking the appropriate boxes:

- ☐ Mental Health Records
- ☐ HIV or AIDS Records
- ☐ Sexually Transmitted or other Communicable Diseases
- ☐ Genetic Testing Records
- ☐ Alcohol/Substance Abuse Records
- ☐ Abortion
- ☐ Maternity Records
- ☐ Sexual/Physical/Mental Abuse

***This authorization will not release psychotherapy notes. If you want to authorize the use or disclosure of psychotherapy notes, a Psychotherapy Notes Authorization Form must be submitted.**

Purpose for the Release of Information:

☐ At the request of the member, or

☒ If not requested by the member, state the purpose of the release of the information: _____

FOR DISCOVERY BEFORE TRIAL

Expiration Date: If not previously revoked, this authorization will terminate on the earliest of the following dates:

1) One year from the signature date below; or

3) Upon the following date, event or condition: _____

(If an event or condition is specified, the company must be notified in writing of the even or condition for revocation to be effective.)

A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. This authorization is voluntary and is not a condition of my enrollment in a health plan, eligibility for benefits or payment for claims. I understand that *IF* this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations, my information described above may be re-disclosed by the recipient and no longer protected by the federal privacy regulations. This authorization is subject to revocation at any time upon written notice to the person/company specified below except to the extent that the person/company has already taken action on the disclosure provision contained in this document.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to BlueCross BlueShield of Tennessee, Privacy Office, 1 Cameron Hill Circle, Chattanooga, TN 37402-2555. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

× _____ _____

(Signature of Adult Member, Parent on Behalf of Minor, As Applicable) (Date)

× _____ _____

(Signature of Legal Representative, If Applicable) (Date)

If a legal representative signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form (e.g. Power of Attorney, guardianship, conservatorship, custody, etc).

You Are Entitled To A Copy Of This Authorization

Please return complete form to:
Paige Thomas
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402