Excellus

A nonprofit independent licensee of the BlueCross BlueShield Association

AUTHORIZATION TO SHARE MY PROTECTED HEALTH INFORMATION

To comply with Federal HIPAA regulations, health plans must obtain a member's permission to share that member's protected health information with any other person. There are limited exceptions to this rule. Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents do not have access to diagnosis or treatment information, including payment information, for venereal diseases, abortion, and drug and alcohol abuse, unless the child specifically authorizes the release of such information.

As a member, you can use this form to authorize us to share your protected health information. Each person you identify will have the same access to your information. If you would like each person to access *different* information or to have access to your information for a *different* period of time, you'll need to complete separate forms for each individual or time period.

This authorization will include the disclosure of information relating to genetic testing, alcohol and drug abuse, mental health (excluding psychotherapy notes), abortion, and venereal disease information only if you place your initials on the corresponding line in Step 2. Additionally, if you would like to authorize us to release information regarding HIV/AIDS, a different form must be completed. To obtain a copy of this form please contact our office at the telephone number listed on your identification card, or access the form at the following website: http://www.health.state.ny.us/diseases/aids/forms/informedconsent.htm.

Your authorization is completely voluntary. We will not condition your enrollment in a health plan, eligibility for benefits, or payment of claims on giving this authorization. If you need additional forms, you may copy this form, visit our Web site at: www.excellusbcbs.com/download/forms/authform.pdf, or contact our office at the telephone number listed on your identification card.

As permitted by law, we will continue to communicate to providers of care involved in your treatment: (1) our payment activities in connection with your claims, (2) your enrollment in our health plan and (3) your eligibility for benefits.

☐ **Please check here if you would like to authorize access to psychotherapy notes. If this box is checked, then this authorization cannot be used for another reason. If checked, steps two and three below can be skipped.**

Step 5: Indicate when you would like us to share your information: *Please share my protected health information during the time period(s) below:*

- ❑ Until Excellus Health Plan, Inc., completes the activities outlined in Step 2.
- ❑ Until I send Excellus Health Plan, Inc. a form canceling my authorization.
- ❑ From _____/_____/_____ through _____/_____/_____

Step 6: Member signature: *To give Excellus Health Plan, Inc. authorization to share the protected health information noted above, please print your name on the line below and then provide your signature and today's date.*

I, _____ have had full opportunity to read and consider the contents of this
(Print Name Above)
form, I confirm my authorization for the use, request and release of my confidential member protected health information as described in this form. I understand that I may cancel this authorization at any time by completing an authorization cancellation form and sending it to the address below. I also understand that the revocation of this authorization will not take effect until Excellus Health Plan, Inc. receives my authorization cancellation form and will not affect any actions Excellus Health Plan Inc. took in reliance on this authorization before they received the authorization cancellation form.

I understand that the information disclosed as a result of this authorization may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the federal privacy laws.

Signature:_____ **Date:**_____
(Member or Personal Representative)

If this request is by a personal representative on behalf of our member, please give us the following information:

Personal Representative's Name: *(please print)*_____

Description of Personal Representative's Authority (a power of attorney, legal guardian or state executor):

_____

Please note: personal representatives must provide legal proof of representation, such as power of attorney documentation.

This form can be completed real time by visiting our Web site at www.excellusbcbs.com/members/account_manager/index.shtml. Select the option to 'Share Your Protected Health Information'.

OR

Please complete and return this form to:

Excellus Health Plan, Inc.
P.O. Box 22999
Rochester, NY 14692

OR

FAX: 1-315-671-7079

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS

Please be sure to complete all of the following steps.

Step 1: Member to whom this authorization applies. *Please use one form per member.*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Member ID Number(s): _____ Birth Date: ____/____/____

Step 2: Reasons to share your information. *So Excellus Health Plan, Inc. can:*

☒ Respond to all requests for confidential information about me made by the individual(s) or organization(s) I list below.

☐ I choose to include information regarding the following conditions in this authorization (please initial next to all that apply):

_____ Genetic testing

_____ Alcohol or substance abuse

_____ Mental health

_____ Abortion

_____ Venereal diseases

(Please note: You must complete a separate form to authorize release of information related to HIV/AIDS. The New York State-approved consent form can be found at: http://www.health.state.ny.us/diseases/aids/forms/informedconsent.htm

☐ Respond to requests for only the following specific information (such as claims submitted by a specific provider or information related to one of the protected diagnosis listed above):

*Please specify*_____

☐ Respond to inquiries related to a specific date of service:

*Please specify*_____

Step 3: Specific information you'd like us to share: *Please list the specific protected health information you wish us to disclose. Check all that apply:*

- ☐ My claim information (e.g. status, type of service, diagnosis, provider, dates of service, etc.)
- ☐ My membership information (e.g. coverage information, enrollment dates, eligibility, address, dates of birth, etc.)
- ☐ My benefit information (e.g. benefits available, benefits used, contract limits, etc.)
- ☐ My medical records (e.g. physician or hospital records, case management, etc.)
- ☐ Other information (please specify):_____
- ☐ Please exclude the following information:_____

Step 4: Indicate with whom you'd like us to share your information: *Please list the person(s) and/or organization with which you want us to share the information you described above. Please remember if you'd like us to share information with more than one person, the information to be disclosed and the expiration date must be the same for each person.*

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