Authorization for Release of Health Information Form Instructions

The Authorization for Release of Health Information form must be completed and signed by you **before** CareFirst can share your health information with a third party such as a spouse, broker, or relative.

- The Authorization form is valid for one year from the date you sign the form or a shorter time period identified by you on the form.
- You will need your membership card to complete this form.

SECTION A

Please provide the member name, address, telephone number and member number in the spaces provided.

SECTION B

In the "**Health Plan or Business Associate Authorized to Disclose (Release) this Information**" section, please check the plan name listed on your membership card. For example, BlueChoice, PPO and Blue Preferred are examples of plan names. If no plan name is listed on your card, write CareFirst in the plan name space.

In the "**Individuals/Organizations Authorized to Receive the Information**" section, list the individual(s), organization or institution to whom CareFirst can release your information. For example, "my broker, John Doe," or "my granddaughter Jane Doe."

In the "**Type of Health Information to Be Used or Disclosed**" section, write the specific health information to be released. For example, "The medical records related to my hip surgery in June 2002," or "All my medical records," or "all of the records related to my heart problems." You may also select from options relating to claims or premium payment information.

SECTION C

The authorization is valid for one year from the date of signature unless you check one of the options listed in this section.

SECTION D

Please sign and date the form before mailing or faxing it to the CareFirst Privacy Office. We are not able to process incomplete forms.

CareFirst Privacy Office
c/o CareFirst BlueCross BlueShield
10455 Mill Run Circle, TBP-06
Owings Mills, MD 21117
Fax: 410-561-7988
Phone: 410-308-8300 or 800-853-9236

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

(Note: If the form is not complete, signed, and dated, it becomes invalid and cannot be accepted.)

Please Print or Type:

SECTION A: The Individual (or the Individual s Personal Representative) confirming the authorization.

I hereby authorize the use and/or disclosure of my identifiable health information as described in Section B below. I understand the following:

1. that this authorization is voluntary and is being provided at my request;
2. that the information disclosed (released) based on this authorization may no longer be protected by federal privacy laws if the individual or organization authorized to receive the information is not a health plan, healthcare provider, or healthcare clearinghouse;
3. that the information disclosed based on this authorization may be subsequently re-released by the individual or organization authorized to receive the information;
4. that when I sign this form, I am authorizing the information selected in section B below to be disclosed to the named individual(s) and/or organization(s). This information may include mental health and substance abuse information if I so choose; and
5. that this authorization will not be used for medical underwriting; therefore, my treatment, payment, enrollment or eligibility for benefits will not be conditioned on my signing this authorization.

Last Name: ______________________ **First Name:** ______________________ **MI**: ___

If not the Policy Holder, **Name of Policy Holder: Last Name:** ___________________ **First Name:** ________________

Street Address: ____ Apt #: ______________

City: ___________________________________ **State:** __________ **Zip:** ________________

Phone: (home) ___________________ **(work)** _______________________

Member # (include 3 letter prefix, if applicable): _____________________________ **Date of Birth:** ____/____/_____

Group Health Plan or Employer Name: __________________________________

SECTION B: The use and/or disclosure being authorized by the person named above.

Health Plan or Business Associate authorized to Disclose (Release) the information: Identify the health plan or health plan administrator (as it appears on your health benefits identification card) that is authorized to disclose your health information:

_____ BlueChoice _____ BluePreferred (PPO)

_____ MD Point of Service _____ Indemnity

_____ Preferred Provider Organization (PPO)

_____ Other ___________________________

Individuals/Organizations authorized to receive the information: Identify the individual or organization to whom the health plan or health plan administrator is authorized to disclose your health information (e.g., the person's name, the broker's name or firm, the disability company etc):

____

____

Type of Health Information to be used and/or disclosed: Provide a written description of the health information you are authorizing the health plan or health plan administrator to use and/or disclose; OR select the type of information from the options provided here (check all that apply):

____

____

____

(1) Claims Information, including payment status and/or procedure/service or condition (select those that apply):

_____ ALL _____ Medical

_____ Dental _____ Vision

_____ Prescription _____ Mental Health

_____ Substance Abuse ______Other

(2) Premium Payment Information (select those that apply):

_____ ALL _____ Medical _____ Dental _____ Vision _____ Prescription

(3) If you want to limit the disclosures, please specify how the health plan or health plan administrator should limit the release of any information (select one from the items below):

By Dates of Service:
From ____/____/____To ____/____/_____

By Health Care Provider:
____

Only Claim #(s):
____

Information related only to a specific procedure, service or condition: (e.g. Heart Surgery or Pregnancy)
____
____

SECTION C: Expiration and Revocation

Expiration: This authorization will expire in one year unless you select and complete one of the options below) :

☐ On ____/____/_________

☐ Upon the happening of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized, e.g. after heart surgery or at the end of the pregnancy):

____

☐ For the duration of my enrollment with the health plan or one year from date of the signature, whichever comes first.

Right to Revoke (cancel): I understand that I may revoke this authorization at any time by giving written notice of my revocation to my health plan or health plan administrator. In order to revoke this authorization, I understand that I may contact Member Services, write a letter or download a revocation form from the web site at www.carefirst.com. I understand that revocation of this authorization will not affect any action that my health plan or health plan administrator, or others named or unnamed herein, took before my health plan or health plan administrator received my written notice of revocation.

The Notice of Privacy Practices includes information about the opportunity to revoke an authorization, and the exceptions to this right. You may refer to the Notice of Privacy Practices for this and all other information pertaining to your Privacy rights.

SECTION D: Signature

I, _______________________________________, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to my health plan or health plan administrator. I understand that by signing this form, I am confirming my authorization that my health plan or health plan administrator may use and/or disclose the protected health information described above to the persons and/or organizations named in this form.

Signature: __________________________________Date: ____________________________

If a personal representative signs this authorization on behalf of the member, complete the following:

Personal Representative's Name: ____

Relationship to Individual: _______________________

___ Health plan or health plan administrator already has a copy of the form designating me as the personal representative on file.

___ Attached is a copy of the form designating me as the personal representative.

Please mail or fax the completed Authorization for Release of Health Information Form to:

CareFirst Privacy Office
c/o CareFirst BlueCross BlueShield
10455 Mill Run Circle, TBP-06
Owings Mills, MD 21117
Fax: 410-561-7988

We will provide you with a copy of this authorization. Please make and keep a copy of it for your records prior to sending it to the health plan, health plan administrator or other party.

Any mental health or substance abuse information, which has been disclosed from medical or other health care records, may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits the recipient of the information from making any further disclosure of this information unless such 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.