



NEBRASKA

An Independent Licensee of the
Blue Cross and Blue Shield Association

P.O. Box 3248 • Omaha, NE 68180-0001

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

ID:

Sub. Last Name:

Acronym: **AUT**

BLUE CROSS AND BLUE SHIELD OF NEBRASKA OFFICE USE ONLY

This form authorizes Blue Cross and Blue Shield of Nebraska (BCBSNE) to release your Protected Health Information. You only need to complete this form if you want BCBSNE to give your Protected Health Information to another person or organization, such as your spouse. "Protected Health Information" (PHI) is information about you that may identify you and relates to your past, present or future physical or mental health or condition and related health services. Please print clearly in blue or black ink.

SECTION A: Individual authorizing release of PHI

YOUR NAME _____

YOUR TELEPHONE NUMBER: (Day) _____ (Evening) _____

YOUR ADDRESS: _____
Street _____ Apartment # _____
City _____ State _____ ZIP Code _____

YOUR MEMBER ID NUMBER (AS SHOWN ON YOUR BCBSNE I.D. CARD)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(ALPHA PREFIX)			(NUMBERS)								

SECTION B: Description of authorization

I hereby authorize Blue Cross and Blue Shield of Nebraska (BCBSNE) to release my Protected Health Information (PHI) as described in this authorization. I understand that my PHI may include, but is not limited to, the following: medical records, emergency care records, billing statements, Explanation of Benefits, diagnostic imaging reports, transcribed hospital reports, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization.

I further understand that my PHI may include information related to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/AIDS, prescription medication, pregnancy/maternity, organ transplants, and chemical dependency (including alcohol and drug treatment).

I further understand that this authorization applies to **ALL** PHI, except for the following limitations (if none, please leave blank): _____

SECTION C: Persons/Organizations authorized to receive my PHI

Please tell us who you are authorizing to receive your PHI by completing the table below.

- For "Person's Relationship To You" please give a general description such as "husband" or "attorney."
- The "Start Date" is the date this authorization will begin.
- The "End Date" is the date this authorization will end. If you do not want this authorization to end on a specific date, please check the "Upon Disenrollment" box. If you leave both the "End Date" **AND** "Upon Disenrollment" boxes blank, this authorization will remain valid until your disenrollment from your health plan or your death. If your coverage is already terminated you **MUST** provide us with a future "End Date".

Individuals Authorized to Receive Your PHI

Name of Person to Receive PHI	Person's Relationship To You	Address	ZIP Code	Telephone Number	Start Date	End Date	Upon Disenrollment



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Purpose for which release is to be made (**NOTE: you are not required to provide a specific purpose; if left blank, BCBSNE will presume that the release is simply being made at your request**): _____

SECTION D: Terms and conditions of this authorization

I understand that I may refuse to sign this authorization. I understand that BCBSNE may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I also understand that if the person(s)/organization(s) authorized to receive my PHI is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I further understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization (**please contact BCBSNE at the address or telephone number listed below to obtain the standard authorization revocation form**). Unless revoked earlier, this authorization will end on the date specified above or upon my disenrollment from the health plan.

SECTION E: Your signature

Signature of Individual: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, please complete the following:

Personal Representative's Name: _____

Relationship to the member (check one of the following):

- Parent.** As the parent of the minor child you are authorized to obtain protected health information (PHI). If you want to authorize another person to receive PHI on this minor child you will need to check this box and write your name in the personal representative field above.
- Legal Guardian, Conservator or Executor.** Please attach legal documentation showing that you are the legal guardian, conservator or executor.
- Power of Attorney.** Please attach legal documentation showing that you hold a power of attorney. If you hold a Health Care Power of Attorney it must be accompanied by a Doctor's certification of incapacity.

**Please return completed and signed form in the enclosed postage paid envelope,
OR to the following address:**

**Blue Cross and Blue Shield of Nebraska
Attention: Privacy Office
P.O. Box 3248
Omaha, NE 68180-0001
FAX Number: (402) 392-4153**

**If you have questions, need additional information or assistance in completing this form,
please contact us at the above address or (402) 343-3521 or Toll Free (877) 258-3999**