Blue Shield
of California

Authorization for Blue Shield of California to Disclose Personal & Health Information to a Third Party

You May Refuse To Sign This Authorization

This form is used to authorize Blue Shield of California to release personal and health information for the purpose stated below.

Section A: This authorization is for the release of the following type of personal and health information:

This authorization is for release of personal and health information related to (please check only one box):

- ☐ Dues payment and billing and information
- ☐ Medical care and treatment (not including mental health/ substance abuse/ HIV care)
- ☐ Mental health/substance abuse* care and treatment
- ☐ HIV* care and treatment

*For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both the patient's treating physician and the patient sign the authorization form before information may be released.

If this authorization is for mental health/substance abuse or HIV information, a separate completed authorization form will be necessary for the release of other types of personal and health information.

Section B: Member Information – This authorization to release information relates to the personal and health information of the following member:

Name: ______________________ Subscriber Number: ______________________

Street Address: ______________________

City: ______________________ State: __________ Zip: __________

Member Number: ______________________ Member Date of Birth: ______________________

Telephone: ______________________

Section C: Disclosure and Use of Member Information – Please read and complete the following statements carefully

No Conditions: This authorization is voluntary. We will not condition our payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits on your giving this authorization.

Personal and Health Information to be Disclosed: The specific personal and health information you are authorizing "Blue Shield" to disclose includes the following:

____

____

Purposes of this authorization: By signing this form, you authorize the use of your personal and health information by a third party for the following purposes:

____

____

Limitations to the use of Personal and Health information:
Blue Shield will obtain specific written authorization or consent for disclosure of any personal and health information, beyond those permitted by law. Blue Shield recognizes your right to specifically approve or to deny the release of information beyond that information which is necessary to administer the health plan or which is permitted by law. Blue Shield will only disclose that information which is reasonably necessary to achieve the purpose of the request for release.

Section D: Persons or Entities Authorized to Receive and Use Member Information

The persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing "Blue Shield" to disclose the personal and health information described above are:

Name:______________________________ Relationship:______________________________

Name:______________________________ Relationship:______________________________

Section E: Expiration and Revocation

This authorization for the release of your personal and health information may be revoked or withdrawn at any time and a revocation or withdrawal will apply to all information not previously released pursuant to this authorization. No other personal or health information may be disclosed without your authorization, unless permitted by law. Request for revocation must be made in writing, unless Blue Shield has taken action in reliance on this authorization or it was obtained as a condition of obtaining healthcare plan coverage.

This authorization for the release of your personal and health information will expire in one year or on the date you specify. Note: if this authorization is for the release of the personal and health information of a minor the expiration date cannot exceed the 18th birthday of the minor.

Expiration: This authorization will expire (specify one):

- ☐ On _____/_____/_____
- ☐ One year from the date indicated below

This authorization may be revoked at any time. Requests for revocation must be made in writing. Please contact Blue Shield to request a form for revocation of this authorization.

Section F: Signature – You May Refuse to Sign this Authorization

I, ____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that "Blue Shield" may use and/or disclose to the persons and/or organizations named in this form the personal and health information described in this form for the purposes stated in this form.

I understand that, if the persons or organizations I authorize to receive and/or use the personal and health information described in this form are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the personal and health information and it may no longer be protected by federal health information privacy laws.

Signature:____ Date:____

Print Name:____

Person or Entity Authorizing Disclosure of Information: If you are signing on behalf of the member, please indicate your relationship to the member and provide copies of verification of your legal right to authorize the disclosure of the member's personal and health information.

- ☐ Parent or guardian of minor patient (to the extent minor could not have consented to the care)
- ☐ Court appointed guardian, legal conservator, legal representative or an individual with Power of Attorney to disclose the member's personal and health information
- ☐ Durable Power of Attorney for Health Care
- ☐ Beneficiary or personal representative of deceased patient
- ☐ Spouse or person financially responsible (where information is solely for purpose of processing an application for enrollment)

You will receive a copy of this authorization after you sign it. A copy of this authorization shall be considered as effective and valid as the original. Additionally, you may inspect or copy the protected health information to be used or disclosed.