SAF

BlueCross BlueShield of Illinois

Standard Authorization Form To Use or Disclose Protected Health Information (PHI)

I. Individual (Name and information of person authorizing disclosure):

Name			**Date of Birth**
Group #	**Identification/Subscriber #**		**Social Security Number**
Address	**City**	**State**	**ZIP**
Area Code & Telephone Number			

II. Authorization and Purpose:

I request and authorize Blue Cross and Blue Shield of Illinois to disclose my protected health information as described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Persons/Organizations authorized to receive your information	**Relationship**	**Purpose**

III. Specific Description of Information to be Used or Disclosed (check one or more):

☐	Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).
☐	Claims Information:	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.).
☐	Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.
☐	Premium Information:	Includes information related to billing cycles, bank draft changes, etc.
☐	Services on [date(s)]:	From: _____ To: _____ (Includes information related to services that occurred during the specific time frame.)
☐	Services from (provider or supplier):	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier.)
☐	Sensitive Health Information Protected Under State Law:	Includes medical information specific to **genetic testing; HIV test results** or medical records including **HIV information**; and records and/or communications relating to **mental health or developmental disability services.**
☐	Other:	_____ (Specify other information authorized for disclosure if it is not listed in one of the categories above.)

This Authorization CANNOT be used to disclose Psychotherapy Notes.

IV. Expiration and Revocation:

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed ☐ Other (insert date or event): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization.

_____ _____

Signature **Date**

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of documents if you already have those documents on file with Blue Cross and Blue Shield of Illinois:

_____ _____

Personal Representative's Name **Relationship to Individual**

_____ _____ _____ _____

Personal Representative's Address **City** **State** **ZIP**

_____

Personal Representative's Area Code & Telephone Number

BEFORE RETURNING
YOU SHOULD EITHER:

(1) MAKE A COPY OF THIS SIGNED AUTHORIZATION FOR YOUR RECORDS; OR
(2) COMPLETE AND SIGN THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED AND KEEP IT FOR YOUR RECORDS.

Mail your completed signed authorization to:
Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112