BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

AUTHORIZATION FOR HEALTH INFORMATION

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This Authorization will permit Blue Cross and Blue Shield of Alabama and its business associates to receive, use and disclose your health information for the purpose of determining your eligibility for enrollment and benefits under the Blue Cross and Blue Shield of Alabama health contract, policy or plan for which you have applied ("Health Contract"). If you do not sign this Authorization, your application for enrollment in the Health Contract will be denied.

Please read and complete the following:

Note: *A separate form for each Applicant, spouse and child must accompany the Health Contract application to be considered for health coverage. Please list home address of each individual.*

Applicant's Name: _____
Last First Initial

Applicant's Social Security Number: __ __ __ - __ __ - __ __ __ __

THE INDIVIDUAL AUTHORIZING DISCLOSURE OF HIS/HER PROTECTED HEALTH INFORMATION:

❑ If Applicant, check here and skip to address. (If spouse or child, please write the individual's name)

Name: _____
Last First Initial

Note: *Please include home address of each individual authorizing disclosure. This may be different from Applicant's address.*

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____- _____-_____

Date of Birth: _____ Social Security Number: __ __ __ - __ __ - __ __ __ __
MM DD YYYY

DESCRIPTION OF YOUR PROTECTED HEALTH INFORMATION TO BE DISCLOSED AND USED:

Any and all records related to (a) your medical history, treatment or other health care services rendered to you and (b) your enrollment in or participation in any individual or group health plan or policy ("your Protected Health Information") as may be requested by Blue Cross and Blue Shield of Alabama or its business associates from time to time for the purposes described below.

PERSON(S) AUTHORIZED TO DISCLOSE, RECEIVE AND USE YOUR PROTECTED HEALTH INFORMATION:

By signing this Authorization, you hereby authorize all of your past or present health plans, physicians, hospitals, clinics, and other health care providers (and their respective business associates) to disclose your Protected Health Information to Blue Cross and Blue Shield of Alabama and its business associates, as may be requested by Blue Cross and Blue Shield of Alabama and its business associates from time to time, for the purposes described below.You also authorize Blue Cross and Blue Shield of Alabama and its business associates to use and disclose your Protected Health Information for the purposes described below.

DESCRIPTION OF EACH PURPOSE OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

You hereby authorize Blue Cross and Blue Shield of Alabama and its business associates to use and disclose your Protected Health Information for the purposes of (a) determining your eligibility for enrollment in and/or your eligibility for benefits under the Health Contract; (b) for offering you coverage under the Health Contract; and/or (c) for notifying the Applicant of the Health Contract application of whether you are denied coverage under the Health Contract and the reasons for any such denial.

DATE OF EXPIRATION OF THIS AUTHORIZATION:

This Authorization will expire three (3) years from the date that you sign this Authorization.

YOUR RIGHT TO REVOKE THIS AUTHORIZATION:

I understand that I may revoke this Authorization at any time by giving written notice to the address listed below. I understand that revocation will not affect any action taken in reliance on this Authorization before you received my written notice of revocation.

Blue Cross and Blue Shield of Alabama
Attn: Customer Service
450 Riverchase Parkway East
Birmingham, Alabama 35244

SIGNATURE OF INDIVIDUAL AUTHORIZING DISCLOSURE OF PROTECTED HEALTH INFORMATION;

I,_____, hereby certify to Blue Cross and Blue Shield of Alabama that I am the individual described herein who is the subject of the Protected Health Information (or the individual's Personal Representative*). I further certify that I have had full opportunity to read and consider the contents of this Authorization and that all statements in this Authorization are true and complete in all respects.

I understand that my Protected Health Information may be re-disclosed by the person(s) I have authorized to receive and use my Protected Health Information and that my Protected Health Information described herein may no longer be protected by federal privacy laws.

Signature: _____ Date: _____

Personal Representative Signature*: _____ Date: _____

*If signed as a Personal Representative, you must describe your authority to act as the Personal Representative of the individual who is the subject of the Protected Health Information (the Individual) by initialing one of the following:

_____ The Individual is an unemancipated minor child, I am the parent and have authority under applicable law to act on behalf of the Individual in making decisions related to health care, and the health information described herein is relevant to my personal representation of the Individual. Please Note: State laws vary regarding legal authority to make health care decisions for your child. If you are unsure whether you have such legal authority, both you and your child must sign this Authorization.

_____ The Individual is an adult, unemancipated minor or emancipated minor, I am the guardian, attorney-in-fact or other authorized representative and have authority under applicable law to act on behalf of the Individual in making decisions related to health care, and the health information described herein is relevant to my personal representation of the Individual. Attached is a copy of the legal document(s) that give me authority to act as a Personal Representative, such as letters of guardianship.

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS AFTER YOU SIGN IT.