AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

BlueCross BlueShield of Delaware
A CareFirst Company

This form is used to authorize Blue Cross Blue Shield of Delaware (BCBSD) to disclose a member's Protected Health Information to the individuals or entities named. This form should NOT be used to request copies of personal records. Complete all applicable sections.

MEMBER INFORMATION. This is the person whose information is to be disclosed.

Name:_____ Date of Birth: _____/_____/_____

Address:_____

Phone Number: ( ) _____ BCBSD ID Number:_____

Is this person the primary subscriber? ☐ Yes ☐ No If not, provide subscriber's name:_____

AUTHORIZATION. Complete this section for ALL Authorizations

I authorize BCBSD to disclose the above Member's protected health information to: (Use the reverse side if additional space is needed.)

Name:_____ Phone Number: ( ) _____

Address:_____

Description of the Information to be disclosed. Describe the information to be disclosed. If you would like to limit your disclosures, please specify.

☐ All claims and membership information ☐ Other (please describe): _____

Purpose of the Disclosure: (Please check only one box.)

☐ Member request ☐ Other (please explain): _____

Complete this section ONLY if you want BCBSD to include this information in its disclosures. Please check all applicable boxes.

I authorize BCBSD to include the following information in any disclosure made to my representative:

☐ Substance Abuse ☐ HIV/AIDS ☐ Genetic Testing ☐ Mental Health Care

EXPIRATION AND REVOCATION: You must specify an expiration date or event.

Expiration: This authorization will expire upon:

☐ This specific date _____/_____/_____ ☐ Termination of my enrollment with BCBSD

☐ The occurrence of the following event and its expected date:_____ ____/____/____

Revocation: You may revoke this Authorization at any time by notifying BCBSD in writing. Your revocation will not affect any action that we took before we received your Notice of Revocation. BCBSD's Notice of Privacy Practices includes information on the Right to Revoke an Authorization and the limitations on that right.

SIGNATURE: Please sign and date. If signed by a Personal Representative, attach authorizing documents (Power of Attorney, Guardianship, etc.)

This Authorization is voluntary. By signing this Authorization, I am confirming that BCBSD may disclose my Protected Health Information as specified herein. I understand that, if the person or organization that I have authorized to receive the information is not subject to federal health information privacy laws, the information may be re-disclosed and will no longer be protected by federal privacy laws. I understand that giving this authorization is not a condition of eligibility for benefits, enrollment in a health plan, or payment of claims.

Signature: _____ Date: _____/_____/_____

IF A PERSONAL REPRESENTATIVE SIGNED THIS AUTHORIZATION, PLEASE PROVIDE THE FOLLOWING:

Name:_____ Relationship to Individual:_____

Address:_____

Phone Number: ( ) _____

Also attach legal documentation that authorizes the representative's signature (Power of Attorney, etc.).

Please return this form by mail to: Privacy Office, BCBSD, Inc., P.O. Box 8835, Wilmington, DE 19899-8835

Or, you may fax this form to: (302)421-3115