**BlueCross of Northeastern Pennsylvania**

Independent Licensee of the Blue Cross and Blue Shield Association
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# Authorization Form

A signed authorization to disclose protected health information is required under federal rules implementing the Health Insurance Portability and Accountability Act (HIPAA).

**Section A - Member Information (Individual whose information will be released):**

| **Name:** (Last, First, Middle Initial, Title [Sr., Jr., III.]) | **Date of Birth:** / / | **Telephone Number:** (including Area Code) |
|---|---|---|
| **Address:** (including ZIP Code) | | **Group Number:** |
| **Member ID Number(s):** (as shown on the member's identification card) | | |

**Section B – Authorized Person (person or organization receiving your information)**

I authorize this health plan and its affiliates to disclose the above individual's protected health information to:

______________________________________________________________________

______________________________________________________________________

(You must include the name, address, and phone number of the person or organization receiving the member information)

**Section C – Description of Information to be released: (type of information that will be used or disclosed).**

**1.** Psychotherapy Notes: _____ (Initials) - Federal law requires a separate authorization to use or disclose psychotherapy notes. If you initial this line, you may not check any other box below.

**2.** Description of the Information to be Disclosed: (Type of information that will be released. Please check only that which applies)

- ☐ Payment Information
- ☐ Case Management Information
- ☐ Disease Management
- ☐ Other: ______________________________________________
- ☐ Enrollment/Membership
- ☐ Claims Information
- ☐ Health Management
- ☐ Pre-Cert / Referral Information
- ☐ Pharmacy Information

**3.** Purpose of Disclosure: ______________________________________________

Examples: At my request; Family member who assists with health insurance issues; Appeal information related to my claim on (date)

**4.** I understand that my specific authorization is needed to release my information pertaining to the items listed below. By initialing, I authorize release of the information pertinent to my case:

**HIV/AIDS _____ (Initials)** **Mental Health _____ (Initials)** **Substance Abuse ______ (Initials)**

**Section D - Expiration and Revocation: (when this authorization will end)**

**Expiration:** This authorization will expire on ____/____/____ or on the occurrence of the following event: (NOTE: The authorization form is valid only for two years unless you have indicated a date that occurs prior to the two-year expiration date.)

______________________________________________________________________

**Right to Revoke:** You may revoke this authorization at any time by contacting Blue Cross of Northeastern Pennsylvania. Your revocation of this authorization will not affect any action taken before receipt of your notice of revocation. (Please see reverse side for contact information.)

**Section E - Personal Representative Information:** Complete this section if a personal representative is authorizing disclosure of the member's information on behalf of the member. See the reverse side of this form for information and directions about personal representatives. A copy of a power of attorney or other court-initiated document will be required, if applicable.

| **Name:** (Last, First, Middle Initial, Title [Sr., Jr., III.]) | **Relationship to the Member:** |
|---|---|
| **Address:** (including ZIP Code) | **Telephone Number:** (including Area Code) |

**Section F- Signature/Date:**

I understand the nature of this release. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits, or payment of claims.

**Signature:** ____________________________________ **Date:** ____________________

The member or member's personal representative must sign and date this form for it to be processed.

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# Directions for Completing the Authorization Form

This form is used to obtain authorization from the member or the member's personal representative to disclose the member's health information to an individual or organization outside this health plan. This form is used when the information is being disclosed for purposes other than treatment, payment, or health care operations; or, when written documentation is needed to show that a member has authorized another to receive specific information about them.

**Section A - Member Information:** Complete all information requested in this section for the member whose information will be released. Be sure to include any letters that appear in front of the member's identification numbers on the ID card.

**Section B - Authorization:**

1. This identifies the individual or organization designated to receive the information. Describe the authorized individual as specifically as possible. **This must always be completed.**

**Section C – Description of Information to be Released**

1. Number one is to be completed if the information to be disclosed includes psychotherapy notes. If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information. If this section is initialed and is included with other information we will contact you to complete a separate authorization form specifically for psychotherapy notes.

   Psychotherapy Notes, as defined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule: *Notes made by a mental health professional that document or analyze the contents of conversations during counseling sessions, which are kept separate from the rest of the member's medical record and* ***exclude*** *medication, prescription, monitoring, counseling session start and stop times, treatment modalities and frequencies, clinical test results, diagnosis, functional status, treatment plan, symptoms, prognosis, or progress summary.*

2. Describe the information that you wish to be disclosed by using the appropriate checkboxes. **This must always be completed.** If more space is needed to describe the information, attach an additional page.

3. Describe the purpose of the requested disclosure (example: to help settle a claim). **This must always be completed.**

4. Number four is to be completed only if you are authorizing the release of HIV/AIDS, Mental Health, or Substance Abuse information.

**Section D - Expiration and Revocation:**

Expiration information must be completed for an authorization to be valid. Include a date or a terminating event, such as final claim determination or termination of enrollment, as required by HIPAA privacy rules. The authorization form is valid only for two years unless you have indicated a date that occurs prior to the two-year expiration date.

To revoke this authorization, contact Blue Cross of Northeastern Pennsylvania using the phone number located on the back of your ID card.

**Section E - Personal Representative Information:** A personal representative is the member's legal guardian, someone who has power of attorney over the member's health care decisions, or a parent, if the member is a dependent child under the age of 18 and not an emancipated minor. Also, a personal representative can be an executor, administrator, or person legally authorized to act on behalf of a deceased member or the member's estate. **Other than a parent acting on behalf of a dependent child under the age of 18 who is not an emancipated minor, we require a copy of the power of attorney or other court-initiated document as proof that the individual named should be recognized as the member's personal representative.** For this form to be processed, it is important that a copy of any applicable power of attorney or other court-initiated document is on file with the health plan.

**Section F - Signature/Date:** The member or the member's personal representative must sign and date this form for it to be processed. **This must always be completed.**

Return completed forms to: Privacy & Security Office
Blue Cross of Northeastern Pennsylvania
19 North Main Street
Wilkes-Barre, PA 18711