BlueCross BlueShield of Illinois

Instructions for Completing Standard Authorization Form to Release Protected Health Information (PHI)

To Complete Form go to Page 4

Use this form to authorize Blue Cross and Blue Shield of Illinois (BCBSIL) to disclose your protected health information (PHI) to a specific person or entity. You may follow the instructions below or call the number listed on your Member ID card if you need help completing the form. You must complete the entire form.

Please note:

- One **authorization form** can be used for multiple services or providers or you can complete the form claim by claim, procedure by procedure, or for services provided during certain time periods.
- The use of the **authorization form** is voluntary.

Section I. Name and information of person whose PHI is being disclosed

Jane Doe Name	05-10-1962 Date of Birth
123456 Group Number	XOP123456789 Identification/Subscriber Number
### - ## - #### Social Security Number	
123 Main Street Address	Anytown City
IL State	12345 Zip Code
555-555-5555 Area Code & Phone Number	

*The information in **Section I** applies to the person whose PHI is being disclosed. The person could be the policy holder, his or her spouse, a dependent or any other person covered under the policy or a person who has their own coverage. In this example, Jane Doe is the person making the request.*

Section II. Authorization and Purpose

I authorize BCBSIL to release my PHI to the person or organization listed below. I understand if the person or organization listed below is not a health plan or health care provider, the PHI may not be protected by federal privacy laws.

Suzy Smith Persons/Organizations authorized to receive your information		Daughter Relationship	
Assisting in medical care Purpose			
123 Main Street Address	Anytown City	IL State	12345 Zip Code

*The information in **Section II** identifies the person or organization that will be receiving the PHI about the person named in Section I. A person that needs access to the PHI could be a family member, a close friend, a broker, or an attorney. If the person wants PHI to go to an organization, please include the area and/or job title of the person at the organization, for example, Benefits Representatives, Human Resources Department, Associate XYZ Insurance Agency, etc. In this example, Jane Doe is authorizing the release of PHI to her daughter Suzy Smith.*

Section III. Description of Sensitive Protected Health Information (SPHI) and PHI to be Released

*Complete **Parts A and B** of this section*

A. Release of SPHI that may be protected under State Law. If you check "yes," you are authorizing BCBSIL to release the SPHI listed below and if applicable to your data release request, it will be included in the information you select in III.B. If you check "no" or make no selection at all, SPHI will not be released. This authorization may not be used for the release of Psychotherapy Notes.

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome,
- Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases),
- Drug, alcohol or substance abuse,
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions), and
- Genetic testing.

Yes	X
No	

*The information in **Section III-A** applies when a person wants specific SPHI as listed above to be released to their authorized representative, the person must specifically authorize that release. In this example, Jane has agreed to let her daughter Suzy Smith receive her SPHI.*

B. Description of PHI to be released. You may select one or more

			Dates of Services From:	To:
☐	Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).		
X	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.).	06-12-15	04-30-18
☐	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 from Provider or Supplier:	Provider/Supplier Name: _____ Describe the exact information you want released:		
☐	Other:	Add other information that is not listed above.		

***Section III-B** is where the person specifies what PHI they are authorizing BCBSIL to release. In this example, Jane is authorizing BCBSIL to release claims information from 6-12-15 to 4-30-18 to her daughter Suzy Smith.*

Section IV. Expiration & Right to Revoke or Terminate the Authorization

Expiration: Select a date/event when authorization will expire. The authorization cannot be processed if this is left blank.

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

Right to Revoke/Terminate: You may end this authorization at any time by giving written notice to BCBSIL at the address listed below; however, **BCBSIL is not responsible for the PHI released before the authorization was terminated.**

*In **Section IV**, the person must select a date when this authorization will end. All valid authorizations must contain a specific expiration date or event; for example: "hospitalization end date", "rehabilitation end date", etc. In addition, BCBSIL is providing information about the right to terminate an authorization at any time. In this example, the authorization remains valid for one year from the date it was signed unless Jane revokes it.*

Section V. Signature & Acceptance of Terms.

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.

Jane Doe	Self	4-30-18
Signature	Relationship	Date (MM-DD-YY)

Document must be signed by the person, the parent of a minor child or the person's authorized representative. If you are a parent signing on behalf of a minor child, please **sign your name** – not the child's name. This authorization will expire when the minor child turns **18** years of age, unless proof of legal guardianship is produced. If you are signing Sas a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and provide copies of the appropriate Legal documents. If these documents are already on file with BCBSIL, you do not need to provide.

Authorized Representative's Name	Relationship to Person

Authorized Representative's Address	City

State	Zip Code	Authorized Representative's Area Code & Phone Number

*In **Section V**, the person identified in Section I signs the form unless the person identified in Section I is a minor under the age of 18 – then the parent or guardian signs the form. In this example, Jane is signing on her own behalf. However, if Jane was a minor, her parent or guardian would sign their name on the form.*

Before sending this form, **make a copy for your records:**

- Photocopy this signed authorization, or
- Complete and sign the duplicate form you received or printed

The rest of the form contains instructions for submitting the form to BCBSIL.
Please keep a signed copy for your records.

BlueCross BlueShield of Illinois

Standard Authorization Form to Release Protected Health Information (PHI)

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- The use of the **authorization form** is voluntary.

Section I. Name and information of person whose PHI is being disclosed

Name _____ Date of Birth _____

Group Number _____ Identification/Subscriber Number _____ Social Security Number _____

Address _____ City _____

State _____ Zip Code _____ Area Code & Phone Number _____

*The information in **Section I** applies to the person whose PHI is being disclosed. The person could be the policy holder, his or her spouse, a dependent or any other person covered under the policy or a person who has their own coverage.*

Section II. Authorization and Purpose

I authorize BCBSIL to release my PHI to the person or organization listed below. I understand if the person or organization listed below is not a health plan or health care provider, the PHI may not be protected by federal privacy laws.

Persons/Organizations authorized to receive your information _____ Relationship _____

Purpose _____

Address _____ City _____ State _____ Zip Code _____

*The information in **Section II** identifies the person or organization that will be receiving the PHI about the person named in Section I. A person that needs access to the PHI could be a family member, a close friend, a broker, or an attorney. If the person wants PHI to go to an organization, please include the area and/or job title of the person at the organization, for example, Benefits Representatives, Human Resources Department, Associate XYZ Insurance Agency, etc.*

Section III. Description of Sensitive Protected Health Information (SPHI) and PHI to be Released

*Complete **Parts A and B** of this section*

A. Release of SPHI that may be protected under State Law. If you check "yes," you are authorizing BCBSIL to release the SPHI listed below and if applicable to your data release request, it will be included in the information you select in III.B. If you check "no" or make no selection at all, SPHI will not be released. This authorization may not be used for the release of Psychotherapy Notes.

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome,
- Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases),
- Drug, alcohol or substance abuse,
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions), and
- Genetic testing.

Yes ☐

No ☐

*The information in **Section III-A** applies when a person wants specific SPHI as listed above to be released to their authorized representative, the person must specifically authorize that release.*

B. Description of PHI to be released. You may select one or more.

			Dates of Services From:	**To:**
☐	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 from Provider or Supplier:	Provider/Supplier Name: _____ Describe the exact information you want released:		
☐	Other:	Add other information that is not listed above.		

***Section III-B** is where the person specifies what PHI they are authorizing BCBSIL to release.*

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

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Section V. Signature & Acceptance of Terms.

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	Relationship	Date (MM-DD-YY)

Document must be signed by the person, the parent of a minor child or the person's authorized representative. If you are a parent signing on behalf of a minor child, please **sign your name** – not the child's name. This authorization will expire when the minor child turns **18** years of age, unless proof of legal guardianship is produced. If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and provide copies of the appropriate Legal documents. If these documents are already on file with BCBSIL, you do not need to provide.

Authorized Representative's Name	Relationship to Person

Authorized Representative's Address	City

State	Zip Code	Authorized Representative's Area Code & Phone Number

Before sending this form, **make a copy for your records:**

- Photocopy this signed authorization, or
- Complete and sign the duplicate authorization form

Mail the signed authorization to:

Blue Cross and Blue Shield of Illinois
PO Box 805107
Chicago, IL 60680-4112

If you need assistance completing the form, refer to the instructions above or call the number listed on your Member ID Card.

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كنت أو شخص تساعده حالياً لديك أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك دون تكلفة. للتحدث إلى مترجم فوري، اتصل برقم خدمة العملاء الموجود على ظهر بطاقة العضوية الخاصة بك. إذا لم تكن عضواً أو لم تكن تحمل بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε τον αριθμό εξυπηρέτησης πελατών που αναγράφεται στο πίσω μέρος της κάρτας μέλους σας. Εάν δεν είστε μέλος ή δεν έχετε κάρτα, καλέστε τον αριθμό 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
Diné Navajo	T'áá ni, éí doodago łaʼda bíká anánílwoʼígíí, naʼídíłkidgo, tsʼídá bee ná ahóótiʼi' tʼáá níikʼe níká aʼdoolwoł. Ataʼ halneʼí bichʼiʼ hadeesdzih nínízingo éí kweʼé daʼíníishgi áká anídaalwoʼígíí bichʼį' hodíílnih, bee nééhózinii bineʼdęę' bikáá'. Kojí atah naaltsoos ná hadítʼéégóó éí doodago bee nééhózinígíí ádingo kojį' hodíílnih 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer podany na odwrocie karty członkowskiej. Jeżeli nie jesteś członkiem lub nie masz przy sobie karty, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو یا کسی ایسے شخص کو جس کی آپ مدد کر رہے ہیں کوئی سوال ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے انگریزی میں سروس کسٹمر نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

BlueCross BlueShield of Illinois

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BCBSIL provides TDD/TYY services and language assistance for incoming callers for deaf, hard-of-hearing and speech-disabled members. Members can utilize their TeleTYpewriter (TTY) or Telecommunication Device (TDD) to access a teletype operator at 1-800-526-0844.