BlueCross BlueShield of North Carolina

MEMBER'S PROTECTED HEALTH INFORMATION (PHI) REQUEST FORM

You may give Blue Cross Blue Shield of North Carolina (BCBSNC) written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you want to authorize a person or entity to receive your PHI upon their request, please provide the information below. Completion of this form is not a condition or requirement of coverage and will not change the way that BCBSNC communicates with you. For example, we will continue to send explanation of benefits (EOB) statements to you upon request. However, if your adult child calls BCBSNC to inquire about you, your protected health information will not be shared with your adult child unless you have given BCBSNC permission to do so by completion of this form.

Please print:

Member's Name: _____

Member's Date of Birth _____/ _____/ _____ BCBSNC ID Number _____

At my request, I authorize BCBSNC to disclose my Protected Health Information (PHI) to:
(If you choose, you may designate more than one person.)

Name: _____ Address: _____

Phone: _____ Relationship to Member: _____

Name: _____ Address: _____

Phone: _____ Relationship to Member: _____

We request that you provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: a) your ID number, b) your date of birth, and c) your address.

I authorize BCBSNC to disclose only the following Protected Health Information to the person designated above. (Check all that apply.)

- ☐ Any information requested
- ☐ Benefit information
- ☐ Premium Payment Information
- ☐ Explanation of Benefits information
- ☐ All claims information
- ☐ Enrollment information
- ☐ All services from a specific health care provider (List provider's name): _____
- ☐ Other (Please list specific PHI): _____

Blue Medicare HMO and PPO Members: *To authorize disclosure of your PHI about mental health/substance abuse services, please call the Mental Health/SA telephone number on the back of your ID card to request a separate authorization form.*

I want the designated person to have access to my PHI until my policy expires OR until the specified date of _____/_____/_____.

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I understand that I may revoke this authorization at any time by giving BCBSNC written notice mailed to the address provided. However, if I revoke this authorization, I also understand that the revocation will not affect any action BCBSNC took while this authorization was valid before BCBSNC received my written notice of revocation.

I also understand that I do not have to authorize anyone to receive my PHI as a condition or requirement for coverage by BCBSNC.

I also understand that if the persons or entities I have authorized to receive my PHI are not health plans, covered health care providers, or health care clearing houses subject to the Health Insurance Portability and Accountability Act (HIPAA), or other federal health information privacy laws, they may further disclose my PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

_____ _____/_____/_____
Signature of Member Date

OR

_____ _____/_____/_____
Signature of Personal Representative Date

If signed by a Personal Representative, please:

a) Print your full name: _____
AND

b) Describe your authority to act for the member (e.g., durable power of attorney, court order, parent of minor child, etc.)
_____
AND

c) Attach the legal document naming you as the personal representative when you return this form.

Note: We will consider the effective date of this authorization to be the date we enter this authorization into our computer system, typically 5 days following receipt. If you would like this authorization to become effective on a date after BCBSNC enters the authorization into its system, please provide the date here: _____/_____/_____.

RETURN THIS AUTHORIZATION TO:

Attention: Data Operations
BCBSNC
P.O. Box 17509
Winston-Salem, NC 27116-7509