Capital

Member authorization form to release information

Dear member,

The enclosed form is used to obtain authorization from the member whose information will be released, or the member's personal representative, to disclose the member's information to an individual or organization not otherwise authorized to receive this information.

This form is also used to receive member authorization to use or disclose a member's psychotherapy notes or to disclose member information related to HIV, mental health, or substance abuse. To authorize release of these types of information, they must be indicated in the enclosed form in Section II.

CORRESPONDENCE UNIT • CAPITAL BLUE CROSS • PO BOX 779519 • HARRISBURG, PA 17177-9519

CapitalBlueCross.com

FAX: 717.651.8731

Directions for completing the member authorization form to release information

Capital

This form is used to obtain authorization from the member or the member's personal representative to disclose the member's information to an individual or organization not otherwise authorized to receive this information. This form is also used to receive member authorization to use or disclose a member's psychotherapy notes or to disclose member information related to HIV, mental health, or substance abuse. This form may only be signed by the member or the member's "personal representative" (see description of personal representative below).

PLEASE PRINT

Member information: Complete all information requested in this section for the member whose information will be released.

Important: Name, address, ID number, and date of birth are required.

- **ID number:** List the ID number shown on the front of the member's Capital Blue Cross ID card. If the member has coverage with Capital Blue Cross under more than one ID number, a separate Member Authorization Form must be completed for each ID number where an authorization is applicable.

Authorization: There are two sections here.

Section I: The first section must always be completed. You must identify the individual(s) or organization(s) to receive the information. Describe the information as specifically as possible. If more space is needed to describe the information, describe on the back of the form. Next, describe why this information is being disclosed or check "This information is being disclosed at the request of the member (or the member's personal representative)." If no purpose of disclosure is given, Capital Blue Cross will assume that this information is being disclosed at the request of the member (or member's personal representative).

Section II: The second section is to be completed only if the information to be used or disclosed includes psychotherapy notes, or if the disclosure involves HIV, mental health, or substance abuse information.

If this authorization is being used for psychotherapy notes, it can only be used for that specific purpose and no other.

Psychotherapy notes are defined in the Health Insurance Portability and Accountability (HIPAA) Privacy Rule as:

> *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.*

Expiration and revocation: Expiration information must be completed for an authorization to be valid. Check one of the three boxes provided to show when you want this authorization to expire. If you check the "specific date" box, you must write in a specific date. If no expiration box is checked, this form will expire 60 months after termination of enrollment with Capital Blue Cross.

To revoke this authorization form, contact the Customer Service number on your ID card.

Personal representative information: A personal representative is the member's legal guardian, someone who has power of attorney over the member's healthcare decisions, or a parent, if the member is a dependent child under the age of 18 and not an emancipated minor. If the parent indicated is not the plan subscriber, we may request supporting birth records or custodial documentation. 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 custodial 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 included when you return this form to Capital Blue Cross.

Signature/Date: The member whose information will be released or the member's personal representative must print their name, sign, and date this form for it to be processed.

Unless directed otherwise, please return this completed and signed form to:

Correspondence Unit
Capital Blue Cross
PO Box 779519
Harrisburg, PA 17177-9519
Fax: 717.651.8731

PLEASE PRINT

Member authorization form to release information

Capital

This form is used to obtain authorization from the member to disclose their information. This form may also be used to request the use of a member's psychotherapy notes. **This form may only be signed by the member whose information will be released or the member's "personal representative"** (see "directions for completing the member authorization form" for a description of "personal representative").

Member information: (Name of member whose information will be released)

Name: (First, Middle Initial, Last, Title {Sr., Jr., III.})	**Date of birth:** (Month/day/year)
Address: (including ZIP Code)	**Phone number:** (Including area code) (Optional)
ID number: (As shown on the member's Capital Blue Cross ID card)	

Authorization: Section I must be completed for all authorizations. **Section II must be completed if member information related to HIV/AIDS, mental health, or substance abuse is to be disclosed, or if psychotherapy notes are used or disclosed.**

Section I: (Please check all applicable boxes).

☐ **I authorize Capital Blue Cross and its affiliates to disclose the above individual's protected health information to:**

Name _____ Phone number _____

Address _____

(You must include the name, address, and phone number of the person(s) or organization(s) receiving the member information. If additional person(s) or organization(s) are being authorized, please list the name, address, and phone number on the back of this form.)

Description of the information to be disclosed: (If more space is needed to describe the information, please describe on back of this form).

☐ All claims and appeals

☐ Specific claims: (specify date(s) of service, claim number(s), etc.)

_____

☐ Billing/enrollment.

☐ Other: (please specify; ensure to use Section II as appropriate).

_____

Purpose of disclosure: (Please describe the reason why this information is needed or check (✓) the following).

☐ This information is being disclosed at the request of the member (or the member's personal representative).

_____

_____

If no purpose of disclosure is given, then Capital Blue Cross will assume that this information is being disclosed at the request of the member (or the member's personal representative).

Section II: I understand that my specific authorization is needed to release my information pertaining to the items listed below. This information will not be subject to release unless these areas are indicated. **By initialing, I authorize release of the information pertinent to my case:**

HIV/AIDS _____(Initials)

Substance abuse _____(Initials)

Mental health _____(Initials)

Psychotherapy notes _____(Initials)

(See "directions for completing the member authorization form" for a description of psychotherapy notes.)

Expiration and revocation: One of the following expiration boxes must be checked (✓).

Expiration: This authorization will expire on: (Check one)

☐ This specific date ___/___/_____

(Please note that even if a specific date is given, this authorization will expire no later than 60 months after termination of enrollment with Capital Blue Cross.)

☐ Termination of enrollment with Capital Blue Cross

☐ 60 months after termination of enrollment with Capital Blue Cross

If no expiration box is checked, then this form will expire 60 months after termination of enrollment with Capital Blue Cross.

Right to revoke: You may revoke this authorization form at any time. Contact Capital Blue Cross Member Services for further instructions. Your revocation of this authorization will not affect any action we take before we receive your notice of revocation.

Personal representative information: Complete this section if a personal representative is authorizing disclosure of the member's information. See "directions for completing the member authorization 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: (first, middle initial, last, title {Sr., Jr., III.})	**Relationship to the member:**
Address: (Including ZIP Code)	**Phone number:** (Including area code)

Signature/Date: The member whose information will be released or the member's personal representative must print their name, sign, and date this form for it to be processed.

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.

Print name: _____

Signature: _____ **Date:** _____

☐ Please check (✓) this box if you would like to receive a copy of this form.

Unless directed otherwise, please return this completed and signed form to:

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