



## Conditioned Authorization to Use or Disclose Protected Health Information for Enrollment in a Health Plan

*Please print clearly and use only black ink.*

By signing below, I authorize Blue Cross and Blue Shield of Georgia (BCBSGA) to obtain any necessary medical records from any physicians, hospitals and/or any other health care providers concerning my care and the care of any family member listed on my Application. I understand this information will be used to determine whether my listed family members and I are eligible for enrollment in the coverage requested.

I understand that BCBSGA will not process my Application for enrollment unless this Authorization is signed and returned with my Application. This Authorization permits BCBSGA to request from health care providers any additional medical information needed to determine my eligibility for coverage and/or the eligibility of any family members listed on my Application. This Authorization will expire within one (1) year of the date indicated below.

I understand that I may revoke this authorization at any time during the application process by submitting a completed Authorization Revocation Form to BCBSGA. I may request an Authorization Revocation Form by contacting BCBSGA or the Broker / Agent assisting with my enrollment. If I revoke this authorization, I understand that I / we will not be considered by BCBSGA for enrollment in a health plan.

Date: \_\_\_\_\_

\_\_\_\_\_  
*Printed name of Applicant*

\_\_\_\_\_  
*Signature of Applicant or Applicant's Personal Representative*

\_\_\_\_\_  
*Printed name of Spouse or Dependent Child over age 18 listed on Application*

\_\_\_\_\_  
*Signature of Spouse or Dependent Children over age 18 listed on the Application\**

\_\_\_\_\_  
*Printed name of Dependent Child over age 18 listed on Application*

\_\_\_\_\_  
*Signature of Dependent Child\**

\_\_\_\_\_  
*Printed name of Dependent Child over age 18 listed on Application*

\_\_\_\_\_  
*Signature of Dependent Child\**

*\*If listed on your application, your spouse and each dependent child over age 18 must sign above.*

### **Designated Legal Representative / Guardian**

If this form is signed by a legal representative / guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the ability of the legal representative to act on the individual's behalf, must be attached.

Legal representative (print full name): \_\_\_\_\_

Legal relationship to individual: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please Keep A copy of this Conditioned Authorization Form for your Records*