



Authorization for Use or Disclosure of Protected Health Information (PHI)

Please print clearly and use only black ink.

Federal Employee Program

By completing this form, I authorize Blue Cross and Blue Shield of Georgia (BCBSGA), its agents or subsidiaries, to use or disclose my Protected Health Information (PHI) for the purposes stated on this form.

I have the right to revoke this authorization at any time by giving written notice of my revocation to BCBSGA. I understand that my revocation will not affect any action taken before my written revocation notice is received. I also understand that PHI used or disclosed under the provisions of this authorization may be subject to re-disclosure by the recipient in which case it may no longer be protected under the HIPAA Privacy Rule.

Part A: Please complete the following information exactly as it appears on your Member Identification (ID) Card. If you are a new member and do not yet have a member ID card, please complete as much information as possible. If necessary, please contact your Employee Benefits Administrator, the Broker / Agent servicing your policy, or a BCBSGA Customer Care Associate for assistance.

<i>Member Last Name</i>	<i>Member First Name</i>	<i>Middle Initial</i>	<i>Suffix</i>
<i>Member ID Number (From Member ID Card)</i>	<i>Social Security Number</i>	<i>Date of Birth (mm / dd / yyyy)</i>	<i>Daytime Telephone (with Area Code)</i>
<i>Member Street Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
<i>Employer Group Name</i>	<i>Employer Group Number</i>	<i>Member Home Fax Number (Optional Entry)</i>	
<i>If you are covered under another BCBSGA Health care Policy, please complete the following blocks. If not applicable, leave blank or enter N/A.</i>			
<i>Other Employer Group Name</i>	<i>Other Employer Group Number</i>	<i>Member ID Number (From Other Member ID Card)</i>	

Part B: I authorize the following persons, classes of persons or entities, to receive my Protected Health Information (PHI). You should check only those blocks that apply to your needs or situation. Please refer to the instructions if you have any questions.

<input type="checkbox"/> My Spouse (Enter Name)	<input type="checkbox"/> The Agent/Broker or Insurance Agency servicing my policy
<input type="checkbox"/> My Domestic Partner (Enter Name)	<input type="checkbox"/> My Employee Benefits Administrator (applicable <u>only</u> if you are covered by a Group Policy)
<input type="checkbox"/> My Adult Children (Enter Name(s))	<input type="checkbox"/> Other Authorized Representative (Enter Name)
<input type="checkbox"/> My Parents (if you are over 18) (Enter Name(s))	<input type="checkbox"/> Other Authorized Representative (Enter Name)

Part C: I authorize the following Protected Health information to be used or disclosed on my behalf. Please check all blocks that apply.

<input type="checkbox"/> All information regarding my health coverage or treatment received <i>(see instructions)</i>	<input type="checkbox"/> Benefits information
<input type="checkbox"/> All claims and payment information	<input type="checkbox"/> Billing information
<input type="checkbox"/> Appeals information	<input type="checkbox"/> Eligibility and enrollment information
<input type="checkbox"/> Psychotherapy notes (<i>* refer to the note listed below prior to checking this block</i>)	<input type="checkbox"/> Other (List)

*** By law, an authorization to release psychotherapy notes cannot be combined with any other authorization. If this authorization is for psychotherapy notes, you must complete a separate authorization for any other type of PHI you want released.**

Part D: Purpose of this authorization. Please check **ONLY ONE** of the following blocks.

<input type="checkbox"/> This authorization allows BCBSGA to respond to all requests, questions or transactions involving my health coverage or status received from the persons or entities designated in Part B above.
<input type="checkbox"/> This authorization allows BCBSGA to respond to all requests, questions or transactions involving my health coverage or status received from the persons or entities designated in Part B above for <i>only</i> the following purposes (list):

Part E: Expiration Date. *(See instructions)*.

This authorization will expire upon the end of my coverage with Blue Cross and Blue Shield of Georgia or on the date specified below.

This authorization will expire on _____ (mm, dd, yyyy)

Part F: I have read the contents of this authorization and understand and agree to the use and disclosure of my Protected Health Information as specified above. I also understand this authorization is voluntary and that it will not condition my enrollment in a health plan, eligibility for benefits or payment of claims.

 (Member Signature) Date: _____

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: _____

Your Completed Forms

Completed forms should be faxed or mailed to the address shown below. *This form cannot be submitted by EMAIL.* Failure to provide all necessary information will result in the form being returned to you. If you require assistance, please contact BCBSGA at the number shown on your ID card.

Please FAX to 1-877-868-7950 or mail to Blue Cross and Blue Shield of Georgia, Federal Employee Program, P.O. Box 7037, Columbus, GA 31908-7037

Please Keep a Copy of this Authorization Form for your Records
 A copy will be provided upon your request