

AUTHORIZATION **FOR RELEASE OF PROTECTED** **HEALTH INFORMATION**

I authorize the use and disclosure of my protected health information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I _____, (plan participant) authorize the following
First Name Last Name

individual, or person(s) to receive my protected health information:

1. First Name: _____	Last Name: _____
Date of Birth: _____ mm/dd/yyyy	Relationship to health plan participant: _____ Spouse, Parent, Child, Brother, Sister, etc...

2. First Name: _____	Last Name: _____
Date of Birth: _____ mm/dd/yyyy	Relationship to health plan participant: _____ Spouse, Parent, Child, Brother, Sister, etc...

3. First Name: _____	Last Name: _____
Date of Birth: _____ mm/dd/yyyy	Relationship to health plan participant: _____ Spouse, Parent, Child, Brother, Sister, etc...

The protected health information that may be used and disclosed is as follows:

Personal Health Information relevant to that person's involvement in your care or payment related to your care.

I understand that I may revoke this authorization at any time by sending a written notification to Blue Cross Blue Shield, P.O. Box 400, Grapevine, TX 76099, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand this revocation will not be effective for information that Blue Cross Blue Shield has already used or disclosed relying on this authorization.

This authorization expires upon receipt of a written notification to revoke the authorization.

Group Number: _____ Look on Your ID Card	Member ID: _____ Look on Your ID Card
Plan Participant's Name: _____ Print First Name	Print Last Name
Signature of Plan Participant: _____ Please Sign in Ink	

Please mail or fax this form to: Blue Cross Blue Shield P.O. Box 400 Grapevine, TX 76099
Attention: "Customer Service Department" or Fax # 469-417-1980