

## 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.

**CORRESPONDENCE UNIT • CAPITAL BLUE CROSS • P.O. BOX 779519 • HARRISBURG, PA 17177-9519**

**[capbluecross.com](http://capbluecross.com)**

**FAX: 717.651.8731**



## Directions for Completing the Member Authorization Form To Release Information

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, contract number, and date of birth are all required fields.

- **Contract Number:** Be sure to include any letters that appear in front of the member's Capital BlueCross medical identification number. If member has coverage with Capital BlueCross under more than one contract number, a separate Member Authorization Form must be completed for any applicable authorization related to coverage under each contract.

**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 BlueCross 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 six months after termination of enrollment with Capital BlueCross.

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 health care decisions, or a parent, if the member is a dependent child under the age of 18 and not an emancipated minor. 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 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 BlueCross.

**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 BlueCross  
P.O. Box 779519  
Harrisburg, PA 17177-9519  
Fax: 717.651.8731



## Member Authorization Form To Release Information

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)

<b>Name:</b> (First, Middle Initial, Last, Title {Sr., Jr., III.})	<b>Date of Birth:</b> (Month/Day/Year)
<b>Address:</b> (Including ZIP Code)	<b>Telephone Number:</b> (Including Area Code) (Optional)
<b>Contract Number:</b> (as shown on the member's Capital BlueCross medical identification card; include any letters that appear in front of identification number)	

**Authorization:** Section I must be completed for all authorizations. Section II must be completed only 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 BlueCross 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.)

- |   |  |
|---|--|
| <input type="checkbox"/> All claims and appeals   | <input type="checkbox"/> Billing/enrollment            |
| <input type="checkbox"/> Specific claims: (specify date(s) of service, claim number(s), etc.) | <input type="checkbox"/> Other: (please specify) _____ |

**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 BlueCross 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. 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 six months after termination of enrollment with Capital BlueCross.)

- Termination of enrollment with Capital BlueCross  
 Six months after termination of enrollment with Capital BlueCross

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

**Right to Revoke:** You may revoke this authorization form at any time. Contact Capital BlueCross Customer Service 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.

<b>Name:</b> (First, Middle Initial, Last, Title {Sr., Jr., III.})	<b>Relationship to the Member:</b>
<b>Address:</b> (Including ZIP Code)	<b>Telephone Number:</b> (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:**

**Correspondence Unit  
Capital BlueCross  
P.O. Box 779519  
Harrisburg, PA 17177-9519  
Fax: 717.651.8731**

## Nondiscrimination and Foreign Language Assistance Notice

At Capital BlueCross and our family of companies, our customers and the community we serve are at the heart of everything we do. We know health insurance is complicated, and we're here to make it simple so you can focus on living healthy.

Capital BlueCross and its family of companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Capital BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Capital BlueCross provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters or written information in other formats (large print, audio, accessible electronic format, other formats). Capital BlueCross provides free language service to people whose primary language is not English, such as: qualified interpreters, and information written in other languages.

If you need these services, contact our Civil Rights Coordinator.

If you believe that Capital BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age disability, or sex, you can file a grievance with our Civil Rights Coordinator at Capital BlueCross, P.O. Box 779880, Harrisburg, PA 17177-9880, call 800.417.7842 (TTY: 711), fax, 855.990.9001 or email at [CRC@capbluecross.com](mailto:CRC@capbluecross.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue, SW., Room 509F, HHH Building,  
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice may have important information about your application or coverage through your health plan. Look for key dates in this notice; you may need to take action by certain deadlines to keep your health coverage or help with costs. If you, or someone you're helping, has questions or needs assistance or information about your health plan or this notice, you have the right to get help in your language at no cost. To talk to an interpreter, call 800.962.2242 (TTY: 711).

### Spanish

Este aviso puede contener información importante acerca de su solicitud o cobertura a través de su plan de salud. Ponga atención a la fechas importantes en este aviso; es posible que tenga que actuar antes de ciertas fechas límite para mantener su cobertura de salud o con ayuda del costo. Si usted, o alguien a quien usted ayuda, tiene preguntas o necesita asistencia o información acerca de su plan de salud o este aviso, tiene el derecho de obtener ayuda en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800.962.2242 (TTY: 711).

### Chinese

本通知可能包含有关您的健康计划申请或涵盖范围的重要信息。请注意本通知中的重要日期；您可能需要在具体的截止日期前采取行动维护您的健康涵盖范围或缴纳费用。如果您自己或者您提供帮助的某个人对您的健康计划或本通知有任何疑问或者需要获得帮助或信息，您有权免费获得以您的语言提供的帮助。欲与翻译员通话，请拨打电话 800.962.2242（聋哑人电话 TTY：711）。

## Vietnamese

Thông báo này có thể chứa những thông tin quan trọng về đơn xin của quý khách hoặc phạm vi bảo hiểm trong chương trình bảo hiểm sức khỏe của quý khách hàng. Hãy xem những ngày quan trọng trong thông báo này; quý khách có thể cần xử lý trước khi đến hạn cuối để duy trì bảo hiểm sức khỏe hoặc để giảm chi phí. Nếu quý khách hàng, hoặc người nào đó đang trợ giúp cho quý khách hàng, có câu hỏi hay cần trợ giúp hay thông tin về chương trình bảo hiểm sức khỏe của quý khách, quý khách có quyền yêu cầu được trợ giúp bằng ngôn ngữ của quý khách mà không phát sinh chi phí nào. Để kết nối với thông dịch viên, hãy gọi 800.962.2242 (TTY: 711).

## Russian

Данное уведомление может содержать важную информацию по вашей заявке и медицинской страховке. Просмотрите ключевые даты в этом уведомлении – может понадобиться придерживаться некоторых сроков для сохранения медицинской страховки или же внести плату. Если у вас или помогающего вам есть вопросы, а также нужна помощь или информация по медицинской страховке или по данному уведомлению, позвоните на бесплатный телефон. Для соединения с переводчиком, звоните 800.962.2242 (TTY: 711).

## Pennsylvanian Dutch

Die notice hot vielleicht wichtige information iwwer dei bitt oder coverage darrich dei gesundheitsplans. Guck for die certain days in daere notice; du brauchscht vielleicht ebbes duh bis certain deadlines fa dei gesundheits versicherings bhalde odder fa mit die koschde zu helfe. Wann du, odder ebber ess du am helfe bischt, froge hot odder hilf braucht odder information iwwer dei gesundheits plan odder iwwer die notice, hoscht du die recht fa hilf griege in dei sprooch es nichts koschtet. Fa schwetze mit me dolmetscher, ruf 800.962.2242 (TTY: 711).

## Korean

이 안내문에는 귀하의 건강보험을 통한 신청 또는 보장에 관한 중요한 정보가 포함될 수 있습니다. 이 안내문의 주요 날짜를 확인해 주십시오! 건강보험을 유지하거나 비용 지원을 위해 특정 마감일까지 관련 조치를 해야 할 수도 있습니다. 귀하 또는 귀하가 부양하는 사람이 귀하의 건강보험이나 이 안내문에 관하여 문의 사항이 있거나 도움말 또는 정보가 필요할 때는, 무료로 귀하의 언어를 통하여 도움을 받을 권리가 있습니다. 통역사에게 문의하려면 800.962.2242 (TTY: 711)으로 전화해 주십시오.

## Italian

Questo avviso potrebbe avere importanti informazioni circa la vostra applicazioni o copertura attraverso il vostro programma di salute. Cercate les principali date in questo avviso; potrebbe essere necessario applicare missuri ritoccano alcune scadenze per mantenere le vostre programma di salute o per contribuire con i costi. Se voi, o qualcuno voi state aiutando, ha quesiti o necessita di assistenza o informazione circa il vostro programma di salute o questo avviso, voi avvere può le diritto per ottenere aiuto in la vostra lingua gratuitamente. Per parlare con un interprete, chiamate 800.962.2242 (TTY: 711).

## Arabic

حول التغطية من خلال خططك الصحية. بلحث عن التواريخ التي سيأتي هذا الإشعار؛ بما يتعلق بالاحتياج إلى اتخاذ إجراء م خلال حل طلبك أو بعض الامور التي قد تحتاج إلى التغطية الصحية أو المصاريف. إذا كنت تحتاج إلى مساعدة، أو كنت تتسارع شخصاً آخر، أو كان لديك شكوك أو حاجة إلى المساعدة أو حاجة ذلك حصول على معلومات حول خططك الصحية أو حول هذا الإشعار فلديك إلى هاتف النصي: 711 (800.962.2242). حثف على الحصول على المساعدة قبل غيك الأم من أجل التحدث إلى مخرج فوري، لتصل على الرقم

## French

Le présent avis peut avoir information importante concernant votre application ou la couverture à travers de votre plan sanitaire. Regarde pour clef dates dans cet avis ; vous pourriez devoir prendre des mesures à certaines dates pour maintenir votre plan sanitaire ou de l'aide à payer les coûts. Si vous, ou quelqu'un vous les aidez avoir des questions ou il a besoin d'aide ou information concernant votre plan sanitaire ou cet avis, vous avez le droit à obtenir de l'aide dans votre langue à titre gratuit. Pour parler à un interprète, appel 800.962.2242 (TTY: 711).

**German**

Diese Mitteilung enthält eventuell wichtige Informationen bezüglich Ihres Antrages auf oder Ihres Schutzes durch Ihre Krankenversicherung. Suchen Sie nach Schlüsseldaten in diesem Dokument. Eventuell müssen Sie innerhalb von gewissen Fristen handeln um Ihren Versicherungsschutz zu behalten oder Hilfe mit Kosten zu erhalten. Fall Sie oder jemand, dem/der Sie helfen, Fragen hat oder Hilfe benötigt bezüglich dieser Mitteilung oder der Krankenversicherung, haben Sie Anspruch auf kostenlose Hilfe in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, rufen Sie an unter 800.962.2242 (TTY [Schreibtelefon]: 711).

**Gujarati**

આ નોટિસ માં તમારી અરજી અથવા તમારી આરોગ્ય યોજના મારફતે કવરેજ વિશે મહત્વની જાણકારી હોઈ શકે છે. આ નોટિસ માં મહત્વ ની તારીખો જુઓ; તમારા આરોગ્ય કવરેજ ને જાળવવા માટે અથવા ખર્ચ બચાવવા માટે અમુક ચોક્કસ મુદતો સુધી તમને પગલાં લેવા પડી શકે છે. જો તમે, અથવા જેની તમે મદદ કરી રહ્યા છો, તેમણે કોઈ સવાલ હોય અથવા સહાય કે તમારી આરોગ્ય યોજના અથવા આ નોટિસ વિશે માહિતી જોઈએ, તો તમને તમારી ભાષા માં કોઈ પણ ખર્ચ વગર મદદ મેળવવા નું અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, 800.962.2242 (TTY : 711) ફોન કરો.

**Polish**

To powiadomienie może zawierać ważne informacje na temat Pana/Pani wniosku lub zakresu ubezpieczenia w posiadanym planie. Zalecamy zapoznać się z kluczowymi terminami w tym powiadomieniu; może istnieć konieczność podjęcia działania przed upłynięciem pewnych terminów, aby utrzymać ubezpieczenie zdrowotne lub uzyskać pomoc w kosztach. Jeżeli Pan/Pani lub ktoś, komu Pan/Pani pomaga, ma pytania bądź potrzebuje pomocy lub informacji w sprawie planu ubezpieczenia zdrowotnego albo tego powiadomienia, przysługuje Panu/Pani prawo do nieodpłatnego uzyskania pomocy w ojczystym języku. Aby porozmawiać z tłumaczem ustnym, prosimy zadzwonić pod numer 800.962.2242 (TTY: 711).

**French Creole**

Avi sila a ka genyen enfòmasyon ki enpòtan konsènan aplikasyon w lan oubyen asirans ou atravè plan lasante w la. Chèch e dat enpòtan yo ki nan avi sila a; ou ka gen pou w fè sèten bagay anvan kèk dat limit pou w sa kenbe asirans ou a oubyen pou yo ede w ak kèk depans. Si oumenm, oubyen yon lòt moun w ap ede, genyen kesyon oubyen bezwen èd oswa plis enfòmasyon sou plan lasante w oswa sou avi sila a, ou genyen dwa pou w resevwa asistans nan lang ou pale a san li pa kout e w anyen ditou. Pou w pale ak yon entèprèt, rele 800.962.2242 (TTY: 711).

**Cambodian–Mon-Khmer**

ការជូនដំណឹងនេះអាចមានព័ត៌មានសំខាន់ៗអំពីកម្មវិធីការធានារ៉ាប់រងរបស់អ្នកតាមរយៈគម្រោងសុខភាពរបស់អ្នក។ កម្រិតកាលបរិច្ឆេទសំខាន់ៗនៅក្នុងការជូនដំណឹងនេះអាចធ្វើចំណាត់ការដោយកាលបរិច្ឆេទជាក់លាក់ដើម្បីរក្សាការធានារ៉ាប់រងសុខភាពជួយជាមួយនឹងការចំណាយ។ សិនជាអ្នកនរណាម្នាក់ដែលអ្នកកំពុងជួយសំណួរត្រូវការជំនួយព័ត៌មានអំពីគម្រោងសុខភាពរបស់អ្នកការជូនដំណឹងនេះក៏មានសិទ្ធិដើម្បីទទួលជំនួយជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ។ ដើម្បីនិយាយទៅកាន់អ្នកបកប្រែផ្ទាល់មាត់ សូមហៅទៅកាន់លេខ 800.962.2242 (TTY: 711)។

**Portuguese**

Este aviso pode ter informações importantes sobre a sua aplicação ou cobertura de plano de saúde. Olhe para as datas importantes neste aviso; pode ser necessário tomar medidas em determinados prazos para manter a sua cobertura de saúde ou ajudar com os custos. Se você, ou alguém que você está ajudando, tem dúvidas ou precisa de assistência ou informação sobre seu plano de saúde ou este aviso, você tem o direito de obter ajuda na sua língua sem nenhum custo. Para falar com um intérprete, ligue para 800.962.2242 (TTY: 711).