PREMERA | BLUE CROSS

Authorization for Release of Health Care Information and Records

Instructions:

Use this form to authorize us to share your personal information you describe with the person or entity you name. We would not normally give information to this person/entity.

Please complete this form and be sure to specify:
1) the person or entity you want to receive your personal information
2) the types of information you want us to share with them
3) the purpose for this authorization.

This authorization will remain valid for 24 months or until you tell us in writing to cancel it.

For details on your rights regarding your personal information that we maintain, see our Notice of Privacy Practices. You can find it on our Web site at www.premera.com, or call Customer Service at the number on the back of your ID card for a paper copy.

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AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION AND RECORDS

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Member/Enrollee Name: _____ Date of Birth: _____
(First/MI/Last)

Subscriber Name: _____ Subscriber ID Number: _____
(First/MI/Last)

HEALTH CARE INFORMATION AND RECORDS TO BE RELEASED TO:

Name: _____ Phone: (_____) _____

Address: _____ Fax: (_____) _____

City: _____ State: _____ ZIP: _____

TYPES OF INFORMATION TO BE RELEASED: I permit Premera Blue Cross, and any of its affiliates (the "Company"), to release the following health care information to the person/entity listed above. I understand that the Company needs my written authorization to release any health care information about testing, diagnosis, procedures and/or treatment for alcohol and/or chemical dependency, reproductive health, sexually transmitted diseases (including HIV/AIDS), genetic information or psychiatric disorders/ mental illness. Based on the box(es) I have checked below, the Company may release all diagnostic, procedural, claim, prescription or other related information and records.

- ❑ General Health Care
- ❑ Alcohol and/or Chemical Dependency
- ❑ Reproductive Health (including Abortion)
- ❑ Genetic Information
- ❑ Sexually Transmitted Diseases (HIV/AIDS)
- ❑ Psychiatric Disorders/Mental Illness
- ❑ Other: _____

PURPOSE FOR RELEASE AND HOW INFORMATION WILL BE USED:

- ❑ At the request of the Individual
- ❑ At the request of the Company for:
  - ❑ Research
  - ❑ Marketing
  - ❑ Other: _____
- ❑ Other (please state specific date, specific time period, event or condition): _____

REDISCLOSURE: Information disclosed as a result of this authorization may be redisclosed by the party listed above as the recipient, and may no longer be protected by state and federal privacy rules.

TIMEFRAME OF RELEASE: Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below.

*Signature: _____ Date: _____

Print Name: _____

*If not the member/enrollee, I am the: ❑ Parent ❑ Legal Guardian ❑ Holder of Power of Attorney
If you are the legal guardian or holder of a power of attorney for the member/enrollee, attach legal documentation.

REVOCATION OF RELEASE: I understand that I may change my mind and revoke this release at any time. I will do this by letting the Company know of my decision. Any change will be effective five (5) business days after the Company receives my written notice at the address listed at the bottom of this form. I understand that some or all of this information may already have been shared and that the Company will not be liable for any information already released.

NO CONDITIONS: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Send this form completed to: **Premera Blue Cross, P.O. Box 91102, Seattle, WA 98111-9202**

Please keep a copy of this release for your records.

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