



**Instructions for Completing
Standard Authorization Form
To Complete Form go to Page 4 of 5**

Use this form to authorize Blue Cross Blue Shield of Illinois to disclose your protected health information (PHI) to a specific person or entity. You may follow the instructions we provided below or you may call the Customer Service number listed on the back of your Membership Identification card for assistance in completing the form. You must complete all the fields on this form.

Please remember:

- One **authorization form** can be used for a range of and/or multiple services or providers.
- **Authorization forms** can be completed claim by claim, procedure by procedure, or for services within specified timeframes.
- The **individual's** use of the **authorization form** is always voluntary.

I. Individual (Name and information of person whose protected health information is being disclosed):

Jane Doe		05-10-1962	
Name		Date of Birth	
123456	XOP123456789	###-##-####	
Group #	Identification/Subscriber #	Social Security Number	
123 Main Street	Anytown	IL	12345
Address	City	State	ZIP
312-555-1212			
Area Code & Telephone Number			

All of the information in **Section I** pertains to the individual for whom the authorization is being requested. The individual may be the subscriber, his or her spouse, a dependent or any other **individual** covered or applying for coverage under the subscriber's membership. All fields in this section are **required**. In this example, Jane Doe is the individual for whom the authorization is being requested.

II. Authorization and Purpose:

I request and authorize Blue Cross and Blue Shield of Illinois to disclose my protected health information as described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Suzy Smith	Daughter	Assisting in medical care	
Persons/Organizations authorized to receive your information	Relationship	Purpose	
456 Mill Road	Happytown	IL	45678
Address	City	State	ZIP

Section II identifies the person/entity that will be receiving the PHI about the individual identified in Section I. An individual could authorize disclosure of his or her PHI to a close friend, a broker, an attorney, or a specific member of his or her employer's benefits staff. The individual may also authorize disclosure to an organization. Include the information identifying the organization's job titles to receive the PHI (e.g., Benefits Representatives, Human Resources Department, XYZ Insurance Agency, etc.). In this example, Jane Doe has identified her daughter, Suzy Smith as the person who is authorized to receive her information.

III. Specific Description of Information to be Used or Disclosed *(Please Complete Parts A and B in this Section)*

This Authorization CANNOT be used to disclose Psychotherapy Notes.

Section III will assist in determining what PHI the individual identified in Section I allows the receiving person/entity identified in Section II to receive. This section has two parts, both of which must be completed.

A. Release of Sensitive Protected Health Information Under State Law

You must check “yes” or “no” if you authorize the release of medical information, test results, records or communications specific to *(note: “yes” means this information is included in the categories you designate in Part B below)* :

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome Yes
- Sexually transmitted or “communicable” diseases (includes hepatitis, as well as venereal diseases); No
- Drug, alcohol or substance abuse;
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions); and
- Genetic testing.

Section III A. asks if the authorizing individual identified in Section I wants the receiving person/entity identified in Section II to receive **Sensitive** Protected Health Information (SPHI). SPHI are certain types of health information for which various states’ laws require extra protections. Either “**Yes**” or “**No**” must be chosen. In this example, Jane has agreed to let Suzy receive her SPHI.

B. Release of Protected Health Information *(check one or more)*

Dates of Services
From: To:

<input type="checkbox"/>	Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).	_____	_____
<input checked="" type="checkbox"/>	Claims Information:	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.).	6-12-05	4-30-08
<input type="checkbox"/>	Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.	_____	_____
<input type="checkbox"/>	Premium	Includes information related to billing cycles, bank draft changes, etc.	_____	_____
<input type="checkbox"/>	Services from (provider or supplier):	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier.)	_____	_____
<input type="checkbox"/>	Other:	_____	_____	_____

(Specify other information that is not listed in one of the categories above.)

Section III B. asks for the specific types of information that the individual identified in Section I is authorizing BCBSIL to disclose to the person/entity identified in Section II. In this example, Jane is authorizing BCBSIL to provide her daughter with her claims information for the time period listed. “Dates of Service” means disclosing information for health care services the individual received during a particular time period. For example, in this case Jane Doe is authorizing BCBSIL to disclose claims information for health care services provided during June 12, 2005 through April 30, 2008.

IV. Expiration and Revocation:

Expiration: This authorization will expire on (must choose one):

One year from the date it is signed Other (insert date or event): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

Section IV. asks for the "expiration" date and a statement regarding the individual's right to revoke. All valid authorizations must contain a specific expiration date or expiration event (e.g. "**hospitalization end date**", "**rehabilitation end date**", etc). In this example, the authorization will remain valid for a period of one year from the date it was signed, or until Jane revokes the authorization.

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Jane Doe
Signature

4-30-08
Date: month/day/year

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of these documents if they are already on file with Blue Cross and Blue Shield of Illinois:

_____ Personal Representative's Name		_____ Relationship to Individual	
_____ Personal Representative's Address	_____ City	_____ State	_____ ZIP
_____ Personal Representative's Area Code & Telephone Number			

Section V. requires the signature and date. In order to be valid, the authorization form must be signed by either the individual identified in Section I or the individual's personal representative identified in Section V. If the individual is a minor dependent under the age of 18, a parent or guardian may sign the authorization form. A personal representative has received legal authority to represent the individual. In this case, since Jane is completing the form, there is no need for a personal representative to sign. If Jane's personal representative were signing this authorization on her behalf, the personal representative must complete the lower portion of Section V and submit the proper documentation with the authorization form (if not already on file with BCBSIL).

**BEFORE SENDING AUTHORIZATION FORM
YOU SHOULD KEEP A COPY FOR YOUR RECORDS
BY EITHER:**

- (1) MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR**
- (2) COMPLETING AND SIGNING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED**

The final portion of the form contains some instructions to be followed prior to mailing the form to BCBSIL. Members are advised to keep a signed copy for their records.



**Standard Authorization Form
To Use or Disclose
Protected Health Information (PHI)**

I. Individual (Name and information of person whose protected health information is being disclosed):

Name		Date of Birth	
Group #	Identification/Subscriber #	Social Security Number	
Address	City	State	ZIP
Area Code & Telephone Number			

II. Authorization and Purpose:

I request and authorize Blue Cross and Blue Shield of Illinois to disclose my protected health information as described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Persons/Organizations authorized to receive your information	Relationship	Purpose	
Address	City	State	ZIP

III. Specific Description of Information to be Used or Disclosed *(Please Complete Parts A and B in this Section)*

This Authorization CANNOT be used to disclose Psychotherapy Notes.

A. Release of Sensitive Protected Health Information Under State Law

You must check “yes” or “no” if you authorize the release of medical information, test results, records or communications specific to *(note: “yes” means this information is included in the categories you designate in Part B below)* :

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- Genetic testing.

B. Release of Protected Health Information *(check one or more)*

		Dates of Services	
		From:	To:
<input type="checkbox"/>	Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).	
<input type="checkbox"/>	Claims	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.).	
<input type="checkbox"/>	Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.	
<input type="checkbox"/>	Premium	Includes information related to billing cycles, bank draft changes, etc.	
<input type="checkbox"/>	Services from (provider or supplier):	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier.)	
<input type="checkbox"/>	Other:	_____ (Specify other information that is not listed in one of the categories above.)	

IV. Expiration and Revocation:

Expiration: This authorization will expire on (must choose one):

- One year from the date it is signed
- Other (insert date or event): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Signature _____
Date: month/day/year

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of these documents if they are already on file with Blue Cross and Blue Shield of Illinois:

Personal Representative's Name _____
Relationship to Individual

Personal Representative's Address _____
City _____
State _____
ZIP

Personal Representative's Area Code & Telephone Number

BEFORE RETURNING THIS FORM YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:

- (1) MAKING A PHOTOCOPY OF THE SIGNED AUTHORIZATION; OR
- (2) COMPLETING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

Mail your completed signed authorization to:
Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112

If you need assistance completing the form, please refer to the instructions above or contact the Customer Service number listed on the back of your Member Identification Card.

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the HCSC Privacy Office. Please contact the Privacy Office with any change requests.



If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضواً، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員，或沒有會員卡，請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε τον αριθμό εξυπηρέτησης πελατών που αναγράφεται στο πίσω μέρος της κάρτας μέλους σας. Εάν δεν είστε μέλος ή δεν έχετε κάρτα, καλέστε τον αριθμό 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કોલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago la'da biká anánílwo'ígíí, na'ídiłkido, ts'ídá bee ná ahóótí'i' t'áá níik'e níká a'doolwoł. Ata' halne'i bich'i' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'i' hodíłlnih, bee nééhózinii bine'déé' bikáá'. Kojí atah naaltsos ná hadít'ééggóó éí doodago bee nééhózinígíí ádingo kojí' hodíłlnih 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer podany na odwrocie karty członkowskiej. Jeżeli nie jesteś członkiem lub nie masz przy sobie karty, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulongan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
اردو Urdu	گر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.



**BlueCross BlueShield
of Illinois**

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>

BCBSIL provides TDD/TYY services and language assistance for incoming callers for deaf, hard-of-hearing and speech-disabled members. Members can utilize their TeleTYewriter (TTY) or Telecommunication Device (TDD) to access a teletype operator at 1-800-526-0844.