BlueCross BlueShield of Montana

# Instructions for Completing Standard Authorization Form to Release Protected Health Information (PHI)

To Complete Form go to Page 4

Use this form to authorize Blue Cross and Blue Shield of Montana (BCBSMT) to disclose your protected health information (PHI) to a specific person or entity. You may follow the instructions below or call the number listed on your Member ID card if you need help completing the form. You must complete the entire form.

Please note:

- One authorization form can be used for multiple services or providers or you can complete the form claim by claim, procedure by procedure, or for services provided during certain time periods.
- The use of the authorization form is voluntary.

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## Section I. Name and information of person whose PHI is being disclosed

Jane Doe — Name
05-10-1962 — Date of Birth

123456 — Group Number
XOP123456789 — Identification/Subscriber Number
### - ## - #### — Social Security Number

123 Main Street — Address
Anytown — City

MT — State
12345 — Zip Code
555-555-5555 — Area Code & Phone Number

*The information in Section I applies to the person whose PHI is being disclosed. The person could be the policy holder, his or her spouse, a dependent or any other person covered under the policy or a person who has their own coverage. In this example, Jane Doe is the person making the request.*

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## Section II. Authorization and Purpose

I authorize BCBSMT to release my PHI to the person or organization listed below. I understand if the person or organization listed below is not a health plan or health care provider, the PHI may not be protected by federal privacy laws.

Suzy Smith — Persons/Organizations authorized to receive your information
Daughter — Relationship

Assisting in medical care — Purpose

123 Main Street — Address
Anytown — City
MT — State
12345 — Zip Code

*The information in Section II identifies the person or organization that will be receiving the PHI about the person named in Section I. A person that needs access to the PHI could be a family member, a close friend, a broker, or an attorney. If the person wants PHI to go to an organization, please include the area and/or job title of the person at the organization, for example, Benefits Representatives, Human Resources Department, Associate XYZ Insurance Agency, etc. In this example, Jane Doe is authorizing the release of PHI to her daughter Suzy Smith.*

Section III. Description of Sensitive Protected Health Information (SPHI) and PHI to be Released

*Complete Parts A and B of this section*

A. Release of SPHI that may be protected under State Law. If you check "yes," you are authorizing BCBSMT to release the SPHI listed below and if applicable to your data release request, it will be included in the information you select in III.B. If you check "no" or make no selection at all, SPHI will not be released. This authorization may not be used for the release of Psychotherapy Notes.

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome,
- Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases),
- 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.

Yes [X]
No [ ]

*The information in Section III-A applies when a person wants specific SPHI as listed above to be released to their authorized representative, the person must specifically authorize that release. In this example, Jane has agreed to let her daughter Suzy Smith receive her SPHI.*

| B. Description of PHI to be released. You may select one or more | | Dates of Services From: | To: |
|---|---|---|---|
| [ ] Health Plan Benefit Information: | Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information). | | |
| [X] 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.). | 06-12-15 | 04-30-18 |
| [ ] Service Determination Information: | Includes any information related to pre-service, concurrent and post-service decisions. | | |
| [ ] Premium Information: | Includes information related to billing cycles, bank draft changes, etc. | | |
| [ ] Services from Provider or Supplier: | Provider/Supplier Name: _____ Describe the exact information you want released: | | |
| [ ] Other: | Add other information that is not listed above. | | |

*Section III-B is where the person specifies what PHI they are authorizing BCBSMT to release. In this example, Jane is authorizing BCBSMT to release claims information from 6-12-15 to 4-30-18 to her daughter Suzy Smith.*

Section IV. Expiration & Right to Revoke or Terminate the Authorization

Expiration: Select a date/event when authorization will expire. The authorization cannot be processed if this is left blank.

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

Right to Revoke/Terminate: You may end this authorization at any time by giving written notice to BCBSMT at the address listed below; however, BCBSMT is not responsible for the PHI released before the authorization was terminated.

*In Section IV, the person must select a date when this authorization will end. All valid authorizations must contain a specific expiration date or event; for example: "hospitalization end date", "rehabilitation end date", etc. In addition, BCBSMT is providing information about the right to terminate an authorization at any time. In this example, the authorization remains valid for one year from the date it was signed unless Jane revokes it.*

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Section V. Signature & Acceptance of Terms.

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.

| Jane Doe | Self | 4-30-18 |
|---|---|---|
| Signature | Relationship | Date (MM-DD-YY) |

Document must be signed by the person, the parent of a minor child or the person's authorized representative. If you are a parent signing on behalf of a minor child, please sign your name – not the child's name. This authorization will expire when the minor child turns 18 years of age, unless proof of legal guardianship is produced. If you are signing Sas a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and provide copies of the appropriate Legal documents. If these documents are already on file with BCBSMT, you do not need to provide.

| Authorized Representative's Name | Relationship to Person |
|---|---|

| Authorized Representative's Address | City |
|---|---|

| State | Zip Code | Authorized Representative's Area Code & Phone Number |
|---|---|---|

*In Section V, the person identified in Section I signs the form unless the person identified in Section I is a minor under the age of 18 – then the parent or guardian signs the form. In this example, Jane is signing on her own behalf. However, if Jane was a minor, her parent or guardian would sign their name on the form.*

Before sending this form, make a copy for your records:

- Photocopy this signed authorization, or
- Complete and sign the duplicate form you received or printed

*The rest of the form contains instructions for submitting the form to BCBSMT.*
*Please keep a signed copy for your records.*

BlueCross BlueShield of Montana

# Standard Authorization Form to Release Protected Health Information (PHI)

Use this form to authorize Blue Cross and Blue Shield of Montana (BCBSMT) to disclose your protected health information (PHI) to a specific person or entity. You may follow the instructions below or call the number listed on your Member ID card if you need help completing the form. You must complete the entire form.

Please note:

- One authorization form can be used for multiple services or providers or you can complete the form claim by claim, procedure by procedure, or for services provided during certain time periods.
- The use of the authorization form is voluntary.

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## Section I. Name and information of person whose PHI is being disclosed

Name _____ Date of Birth _____

Group Number _____ Identification/Subscriber Number _____ Social Security Number _____

Address _____ City _____

State _____ Zip Code _____ Area Code & Phone Number _____

*The information in Section I applies to the person whose PHI is being disclosed. The person could be the policy holder, his or her spouse, a dependent or any other person covered under the policy or a person who has their own coverage.*

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## Section II. Authorization and Purpose

I authorize BCBSMT to release my PHI to the person or organization listed below. I understand if the person or organization listed below is not a health plan or health care provider, the PHI may not be protected by federal privacy laws.

Persons/Organizations authorized to receive your information _____ Relationship _____

Purpose _____

Address _____ City _____ State _____ Zip Code _____

*The information in Section II identifies the person or organization that will be receiving the PHI about the person named in Section I. A person that needs access to the PHI could be a family member, a close friend, a broker, or an attorney. If the person wants PHI to go to an organization, please include the area and/or job title of the person at the organization, for example, Benefits Representatives, Human Resources Department, Associate XYZ Insurance Agency, etc.*

Section III. Description of Sensitive Protected Health Information (SPHI) and PHI to be Released

*Complete Parts A and B of this section*

A. Release of SPHI that may be protected under State Law. If you check "yes," you are authorizing BCBSMT to release the SPHI listed below and if applicable to your data release request, it will be included in the information you select in III.B. If you check "no" or make no selection at all, SPHI will not be released. This authorization may not be used for the release of Psychotherapy Notes.

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome,
- Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases),
- 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.

Yes ☐

No ☐

*The information in Section III-A applies when a person wants specific SPHI as listed above to be released to their authorized representative, the person must specifically authorize that release.*

B. Description of PHI to be released. You may select one or more.

| | | | Dates of Services From: | To: |
|---|---|---|---|---|
| ☐ | Health Plan Benefit Information: | Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information). | | |
| ☐ | 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.). | | |
| ☐ | Service Determination Information: | Includes any information related to pre-service, concurrent and post-service decisions. | | |
| ☐ | Premium Information: | Includes information related to billing cycles, bank draft changes, etc. | | |
| ☐ | Services from Provider or Supplier: | Provider/Supplier Name: _____ Describe the exact information you want released: | | |
| ☐ | Other: | Add other information that is not listed above. | | |

*Section III-B is where the person specifies what PHI they are authorizing BCBSMT to release.*

Section IV. Expiration & Right to Revoke or Terminate the Authorization

Expiration: Select a date/event when authorization will expire. The authorization cannot be processed if this is left blank.

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

Right to Revoke/Terminate: You may end this authorization at any time by giving written notice to BCBSMT at the address listed below; however, BCBSMT is not responsible for the PHI released before the authorization was terminated.

*In Section IV, the person must select a date when this authorization will end. All valid authorizations must contain a specific expiration date or event; for example: "hospitalization end date", "rehabilitation end date", etc. In addition, BCBSMT is providing information about the right to terminate an authorization at any time.*

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Section V. Signature & Acceptance of Terms.

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.

Signature | Relationship | Date (MM-DD-YY)

Document must be signed by the person, the parent of a minor child or the person's authorized representative. If you are a parent signing on behalf of a minor child, please sign your name – not the child's name. This authorization will expire when the minor child turns 18 years of age, unless proof of legal guardianship is produced. If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and provide copies of the appropriate Legal documents. If these documents are already on file with BCBSMT, you do not need to provide.

Authorized Representative's Name | Relationship to Person

Authorized Representative's Address | City

State | Zip Code | Authorized Representative's Area Code & Phone Number

Before sending this form, make a copy for your records:

- Photocopy this signed authorization, or
- Complete and sign the duplicate authorization form

Mail the signed authorization to:

Blue Cross and Blue Shield of Montana
PO Box 805107
Chicago, IL 60680-4112

If you need assistance completing the form, refer to the instructions above or call the number listed on your Member ID Card.

BlueCross BlueShield of Montana

**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, sexual orientation, health status 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

BlueCross BlueShield of Montana

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 talk to an interpreter, call 855-710-6984.

| | |
|---|---|
| Español<br>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, llame al 855-710-6984. |
| العربية<br>Arabic | إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984. |
| 繁體中文<br>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, 請撥電話 號碼 855-710-6984。 |
| Français<br>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, appelez 855-710-6984. |
| Deutsch<br>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 Nummer 855-710-6984 an. |
| ગુજરાતી<br>Gujarati | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો. |
| हिंदी<br>Hindi | यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।. |
| Italiano<br>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 numero 855-710-6984. |
| 한국어<br>Korean | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오. |
| Diné<br>Navajo | T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984. |
| فارسی<br>Persian | اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید. |
| Polski<br>Polish | Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984. |
| Русский<br>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 связаться с переводчиком, позвоните по телефону 855-710-6984. |
| Tagalog<br>Tagalog | Kung ikaw, o ang isang taong iyong tinutulungan 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 855-710-6984. |
| اردو<br>Urdu | اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے 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، 855-710-6984 پر کال کریں۔ |
| Tiếng Việt<br>Vietnamese | Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984. |