An independent licensee of the Blue Cross and Blue Shield Association.

A subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.

AUTHORIZATION FOR THE USE / RELEASE OF PROTECTED HEALTH INFORMATION

Purpose: This form is used for an individual to authorize Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as "BCBSLA") to use or disclose the individual's protected health information for the purposes stated.

Instructions: Items with a "*" are required to be completed. If this authorization is for the release of psychotherapy notes, genetic information, HIV/AIDS records, metal and nervous records, or alcohol and drug abuse records, please check the appropriate box in Section B. The form must be signed and dated.

SECTION A: Individual authorizing use and/or disclosure.

*Name: ____

*Address: ____

Telephone: ______________________ Date of Birth: ______________

*Member Number: ____________________ Social Security Number: __________

TO THE INDIVIDUAL: Please read the following and complete the information requested.

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan or eligibility for benefits on receiving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION B: The use and/or disclosure being authorized.

***Purpose of this Authorization: (Please check one of the following and write in the purpose if the individual is not the one requesting the release of information). "**

__ At request of individual (or the individual's personal representative).

__ For the following purposes:

____

____

Protected Health Information to Be Used and/or Disclosed:

*** Specifically and meaningfully describe the protected health information that this authorization will allow to be used and/or disclosed:**

____

____

____

__ Check if this authorization is for genetic information

__ Check if this authorization is for alcohol or drug abuse records

__ Check if this authorization is for acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) records

__ Check if this authorization is for mental and nervous records, not containing psychotherapy notes

If this authorization is for psychotherapy notes, it must not be used as an authorization for any other type of protected health information.

__ Check if this authorization is for psychotherapy notes

Note for alcohol or drug abuse records: The following written statement will accompany each disclosure made by BCBSLA, with the member's written consent: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

SECTION C: Entities allowed to disclose and use/receive information.

Entities Authorized to Disclose / Release: Name or specifically describe the persons and/or organizations, including BCBSLA, who will be authorized to disclose / release the protected health information described above:

Person / Organization #1

*Name Blue Cross and Blue Shield of Louisiana

*Address P.O. Box 98029

City Baton Rouge State LA Zip 70898

Person / Organization #2

*Name ____________________

*Address ____________________

City__________State____Zip________

Entities Authorized to Receive and Use: Name or specifically identify the persons and/or organizations, including BCBSLA, whom this authorization will allow to receive and/or use the protected health information described above:

Person / Organization #1

*Name ____________________

*Address ____________________

City__________State____Zip________

Person / Organization #2

*Name ____________________

*Address ____________________

City__________State____Zip________

SECTION D: Expiration and revocation.

*Expiration: This authorization will expire (complete one):

- On ___/___/_____ (MM/DD/YYYY)
- On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

____

____

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the Privacy Office at 5525 Reitz Avenue, Baton Rouge, LA 70809-3802. Revocation of this authorization will *not* affect any action we took in reliance on this authorization before we received your written notice of revocation.

SECTION E: INDIVIDUAL'S SIGNATURE.

You are entitled to a copy of this authorization after you sign it.

I, *____________________, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

*Signature: ______________________________ *Date: ____________________

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

SECTION F: LEGAL REPRESENTATIVE

If this authorization is signed by a legal representative * or someone other than the member on behalf of the person listed in Section E, complete the following:

Personal Representative's Name: ______________________________

Relationship to the Individual: ______________________________

NOTE: You MUST attach legal documentation of guardianship or Power of Attorney. This documentation is required to process the authorization form.

* Legal representative is a legal designation and generally refers to the parent of a minor, legal guardian, or holder of Power of Attorney