Blue Cross MedicareRx (PDP)℠
P.O. Box 3897, Scranton, PA 18505

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 MedicareRx℠ 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)*** :

- 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 ☐

B. Release of Protected Health Information *(check 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	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	Includes information related to billing cycles, bank draft changes, etc.		
☐	Services from (provider or supplier)	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier.)		
☐	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

_____ _____

Personal Representative's Name **Relationship to Individual**

_____ _____ _____ _____

Personal Representative's Address **City** **State** **ZIP**

_____

Personal Representative's Area Code & Telephone Number

BEFORE RETURNING 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

Mail your completed signed authorization to:
Blue Cross MedicareRx (PDP)
P.O. Box 3897, Scranton, PA 18505

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