

CONFIDENTIAL INFORMATION RELEASE FORM
(To authorize BCBSAZ to disclose and/or update your information)



You must use a separate form for the release of HIV-related information. Return this completed form with your application. Current BCBSAZ customers should mail this completed form to Blue Cross Blue Shield of Arizona, Attention: Enrollment Services, P.O. Box 13466, Phoenix, AZ 85002. Blue Cross Blue Shield of Arizona (BCBSAZ) will not condition its payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits in our health plan on you giving this authorization.

Information to be Disclosed: I authorize BCBSAZ to disclose the following information, including information about communicable diseases, alcohol and drug abuse treatment and genetic testing: *(Please check all that apply.)*

- | | |
|---|--|
| ☐ Application, Enrollment, Eligibility Information | ☐ Billing/Payment Information |
| ☐ Claims/EOB Information | ☐ Medical Records |
| ☐ Precertification Information | ☐ Account Information |
| ☐ Other (please describe): _____ | |

Person Whose Information May Be Released: _____

Who May Receive the Indicated Information:

Name: _____
Company Name: _____
Street Address: _____
City, State, Zip Code: _____

Purpose of Use/Disclosure:

- ☐ To assist with obtaining a health care policy ☐ To assist with claims processing and/or payments
☐ Other Purpose of Use/Disclosure: _____

Authority to Update My Records: I also authorize _____ to be able to:

- ☐ Change My Mailing Address ☐ Update My SurePay/Banking Information

Unless you revoke this authorization earlier, it will expire 90 days after the expiration or termination of your coverage with BCBSAZ. It is possible for the protected health information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer protected by federal health information privacy laws. **You may revoke this authorization by giving written notice to the BCBSAZ Privacy Office, Mail Stop C302, P.O. Box 13466, Phoenix AZ 85002-3466. Revocation of this authorization will not affect any action BCBSAZ took in reliance on this authorization before it received your written notice of revocation.**

_____ Printed Name	_____ Identification Number
_____ Signature	_____ Date (mm/dd/yyyy)
_____ Group Name (if applicable)	_____ Group Number (if applicable)
_____ Personal Representative's Name *	_____ Relationship to Individual
_____ Personal Representative's Signature	_____ Date (mm/dd/yyyy)

* Please attach a copy of the relevant legal document(s)

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

INSTRUCTIONS FOR COMPLETING CONFIDENTIAL INFORMATION RELEASE FORM



Please complete the Confidential Information Release Form if you would like Blue Cross Blue Shield of Arizona (BCBSAZ) to share your personal information with the individual or organization you specify on the form. Each individual 18 and over should complete a separate form.

This authorization is voluntary. We will not condition our claim payment activities, your enrollment in our health plan or your eligibility for benefits on you giving us this authorization.

Examples of Use

Here are a few examples for which the form may be used. Complete the form if you would like BCBSAZ to share certain or all of your personal information with:

- Another adult such as a spouse, parent, child or personal representative so they can discuss your claims or billing questions with BCBSAZ.
- Your broker during or after the enrollment process for the level of service he or she is to provide (enrollment, claims and/or billing questions, etc.)
- Your attorney for a specific legal issue that arises, such as a personal injury case.

Specific Instructions

Information to be Disclosed: Indicate the specific information you want to share (application, enrollment, eligibility, EOBs, claims, medical records, etc.)

Person Whose Information May Be Released: Enter the name of the person whose information should be disclosed. This will normally be your name.

Who May Receive the Indicated Information: Tell us who you are authorizing to receive your information.

Purpose of Use/Disclosure: Tell us why you want us to share your information.

Authority to Update My Records: Tell us if the person you indicate is authorized by you to update our records if you move to a different address, change banks or change bank accounts.

Expiration Date: This authorization will automatically expire 90 days after your last coverage date. You have the right to revoke this authorization earlier by contacting the Privacy Office.

Identification Number and Group Number: Enter your BCBSAZ ID number if you've received one; otherwise enter your social security number.

Signature: Print and sign your name and date the form.

Group Name and Number: If applicable, enter the name and number of the employer or other insured group under which you are covered.

Personal Representative: A personal representative is a legal designation and generally refers to parent of an unemancipated minor, Legal Guardian, or Holder of Power of Attorney. If you are the Personal Representative and are completing this form for someone else, please complete the last two rows and attach copies of relevant legal documents.