# Instructions for Completing Confidential Information Release Form


An Independent Licensee of the Blue Cross and Blue Shield Association

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 us.
- 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 us to share (application, enrollment, eligibility, EOBs, claims, medical records, etc.)

Person About Whom the Above Information Relates: Enter the name of whose information should be disclosed. This will normally be your name.

Entities Receiving Information: Tell us with whom you want us to share your information.

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

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.

# Confidential Information Release Form

(To authorize BCBSAZ to disclose your information)


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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, Arizona 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 About Whom the Above Information Relates: _____

Entities Receiving Information: I authorize BCBSAZ to disclose the above information to:

Name: _____

Company Name: _____

Address: _____

City, State, Zip code _____

Purpose of Use/Disclosure: I authorize BCBSAZ to use and/or disclose the above information for the following purpose:

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

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, C105, BCBSAZ, 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.

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|---|---|
| _____ Printed Name | _____ Identification Number |
| _____ Signature | _____ Date |
| _____ Group Name (if applicable) | _____ Group Number (if applicable) |
| _____ Personal Representative's Name* | _____ Relationship to Individual |
| _____ Personal Representative's Signature | _____ Date |

*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.**