

I would like this authorization to expire on (enter date):

MONTH DAY YEAR
[] [] / [] [] / [] [] [] []

OR When my policy expires.

(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt)

I understand that I may revoke this authorization at any time by giving BCBSNC written notice mailed to the address below. However, if I revoke this authorization, I also understand that the revocation will not affect any action BCBSNC took in reliance on this authorization before BCBSNC received my written notice of revocation.

I also understand that BCBSNC will not condition the provision of health plan benefits on this authorization.

I also understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act ("HIPAA") or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

Signature: _____ Date: MONTH DAY YEAR
[] [] / [] [] / [] [] [] []

If signed by a personal representative: _____
PRINT YOUR FULL NAME

Describe your authority to act for the member (e.g. power of attorney, court order, parent of minor child, etc.):

NOTE: Please attach the legal document naming you as the personal representative if you have not previously submitted it to us.

NOTE: BCBSNC will consider the effective date of this authorization to be the date BCBSNC enters this authorization into its Commercial Operations business system, typically 5 days following receipt.

If you would like this authorization to become effective on a date after BCBSNC enters the authorization into its system, please insert the date here:
MONTH DAY YEAR
[] [] / [] [] / [] [] [] []

RETURN THIS AUTHORIZATION TO:
Federal Employee Program / IDC
Blue Cross and Blue Shield of North Carolina
P.O. Box 2291
Durham, NC 27702-2291