



North Carolina Medical Society Employee Benefit Plan

MEMBER'S AUTHORIZATION REQUEST FORM

You may give the North Carolina Medical Society Employee Benefit Plan (NCMS Plan) and its administrator Blue Cross and Blue Shield of North Carolina (BCBSNC) written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. **Completion of this form will not change the way that NCMS Plan and BCBSNC communicate with members or subscribers. For example, explanation of benefits (EOB) will continue to be sent to the subscriber.**

Member's Name _____ Subscriber's Name (if different) _____ Member's Date of Birth ___/___/___

Subscriber ID Number _____ Group Number (from ID card, if applicable): _____

At my request, I authorize disclosure of my Protected Health Information to: (enter name of person/entity who will receive your PHI)

(Name) (Address) (Relationship to Member)

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: (i) your subscriber ID number, (ii) your date of birth, and (iii) your address.

I authorize disclosure of the following PHI to the person/entity listed above. Check all that apply:

- Any information requested
- Enrollment information
- Benefit information
- Premium payment information
- All claims information
- Explanation of Benefits (EOB) information
- All services from a specific health care provider (List provider's name): _____
- Other (Please list specific PHI): _____

If you want to authorize someone to have access to your mental health or substance abuse PHI, please call the mental health/substance abuse telephone number on the back of your membership card to request a separate authorization form.

I would like this authorization to expire on (enter date): ___/___/___ **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 written notice mailed to the address below. However, if I revoke this authorization, I also understand that the revocation will *not* affect any action in reliance on this authorization before receipt of my written notice of revocation.

I also understand that the provision of health plan benefits is not conditioned 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

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):

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

Note: We will consider the effective date of this authorization to be the date it is entered into the business system, typically 5 days following receipt. If you would like this authorization to become effective on a later date, please insert the date here:
_____/_____/_____.

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