MEMBER'S AUTHORIZATION REQUEST FORM

You may give 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 BCBSNC communicates with members or subscribers.** ***For example, we will send explanation of benefits (EOB) statements to the subscriber.***

MEMBER WHOSE INFORMATION WILL BE DISCLOSED:

MEMBER'S FIRST NAME | M.I. | MEMBER'S LAST NAME

MONTH **DAY** **YEAR** — MEMBER'S DATE OF BIRTH

PREFIX | **9 DIGIT IDENTIFIER** | **SUFFIX** — SUBSCRIBER ID NUMBER *(FROM YOUR ID CARD)*

At my request, I authorize BCBSNC to disclose Protected Health Information to ***(enter name of person/entity who will receive member's PHI)*****:**

FIRST NAME | M.I. | LAST NAME

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)** subscriber address.

I authorize BCBSNC to disclose the following PHI to the person/entity listed above. CHECK ONLY BOXES THAT APPLY:

☐ ALL Information Requested ☐ Enrollment Information ☐ Benefit Information ☐ Premium Payment Information ☐ Explanation of Benefits (EOB) Information

☐ All Claims Information ☐ All Services from Specific Provider(s) *(List Provider's Name)*: _____

☐ Other *(Please List Specific PHI and/or Date Ranges)*: _____

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

NOTE: BCBSNC will consider the effective date of this authorization to be the date BCBSNC enters this authorization into its Dental Blue Select business system, typically five (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**

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: _____ **Today's Date:** **MONTH** **DAY** **YEAR**

If signed by an individual other than the member: _____

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.

RETURN THIS AUTHORIZATION TO:

Dental Blue Select
Blue Cross and Blue Shield of North Carolina
P.O. Box 2400 • Winston-Salem, NC 27102-2400