

Authorization for Release of Information To Agents Pertaining to the Application

Please read these instructions carefully before completing this form.

When to Use This Form

Complete this form if you want Blue Cross to give information about you to an agent .

Parents or a legal guardian may sign for a minor unless the minor is permitted under state law to consent to the treatment. In that case, the minor must sign the authorization.

How to Complete This Form

The Authorization for Release of Information form must be completed and signed by one of the following:

- ◆ The person whose information will be released
- ◆ The parent or legal guardian of a minor whose information will be released except as noted above
- ◆ The personal representative of the person whose information will be released (e.g., power of attorney, conservator, executor)

To complete this form:

- ◆ Fill in the name, member identification and date of birth of the person whose information will be released
- ◆ Check the type(s) of information you want us to release
- ◆ Fill in the name and address of the agent who will receive the information
- ◆ Sign and date the form
- ◆ If you are not the person whose record will be released, state your relationship to that person

Attach this form to application

Blue Cross and Blue Shield of Minnesota
P.O. Box 64024
St. Paul MN 55164-0560
Fax: 651-662-2745

Note: Federal law says that Psychotherapy notes cannot be released using the same authorization form as other records. In order to release Psychotherapy notes, you need to fill out a separate authorization form.

Authorization for Release of Information To Agents Pertaining to the Application Process

Member Information (person granting release of information)

Applicant's Name _____ Applicant's ID# _____
Date of Birth _____

Purpose for this Release (must be checked by applicant for release of information)

Request of applicant or personal representative

Blue Cross may release this information to:

Agent's Name _____
Agency Code and Number _____
Address _____
Phone Number _____

I authorize Blue Cross to release the following information:

Provider's name of Medical Records Requests from BCBSM Underwriting (behavioral health Provider's names are excluded)

Release of medical questionnaire type (behavioral health questionnaires are excluded)

Release of behavioral health questionnaires

If the information relates to behavioral health substance abuse or behavioral health mental health care, we must have the name of the treatment facilities or program(s) to release information:

If the information relates to diagnosis or treatment of behavioral health substance abuse or behavioral health mental health care I understand that the person(s) I have named to receive the information must treat it as confidential. The information cannot be disclosed again without another signed authorization from me. For all information other than diagnosis or treatment of behavioral health substance abuse or behavioral health mental health care, I understand that the person(s) I have named to receive information may not be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect it.

Right to Revoke - I understand that I may cancel this authorization in writing at any time, but it will not affect any release of any information processed before I cancel it.

Signature of Applicant

____ - ____ - ____
Date

Signature of Parent or Personal Representative/Relationship to Member

____ - ____ - ____
Date

This authorization is valid for one year after the date it is signed, unless an earlier expiration date is indicated here: _____

Note: You have a right to keep a copy of this notice after you sign it.