

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Purpose: This form is used for an individual to authorize a health care provider or other entity to disclose protected health information to Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc. (collectively referred to as “BCBSLA”) for the purposes stated.

Instructions: Items with an “*” are required to be completed. If this authorization is for the release of psychotherapy notes, genetic information, or alcohol and drug abuse records, please check the appropriate box in Section B. The form must be signed and dated.

SECTION A: Individual authorizing use and/or disclosure

*Name: _____
 *Address: _____
 Telephone: _____ E-mail: _____
 *Member Number: _____ Social Security Number: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan or eligibility for benefits on receiving this authorization.

Effect of Granting this Authorization: If the protected health information described below is disclosed to and/or received by persons or organizations that are not subject to federal health information privacy laws, these persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. However, BCBSLA is subject to the federal health information privacy laws and the information received by BCBSLA will remain protected by these laws.

SECTION B: The use and/or disclosure being authorized

***Purpose of this Authorization: (Please check one of the following and write in the purpose if the individual is not the one requesting the release of information).**

- At request of individual (or the individual’s personal representative)
- For the following purposes:

Protected Health Information to Be Used and/or Disclosed:

***Specifically and meaningfully describe the protected health information that this authorization will allow to be disclosed.**

- Check if this authorization is for genetic information.
- Check if this authorization is for psychotherapy notes.
- Check if this authorization is for alcohol or drug abuse records.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

Note for alcohol or drug abuse records: The following written statement will accompany each disclosure made by BCBSLA, with the member’s written consent: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

SECTION C: Entities allowed to disclose information

Entities Authorized to Disclose: Name or specifically describe the doctor, hospital, persons, and/or organizations, who will be authorized to disclose the protected health information described above to BCBSLA.

Person / Organization #1	Person / Organization #2
*Name _____	*Name _____
*Address _____	*Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____

SECTION D: Expiration and revocation

Expiration: This authorization will expire upon receipt by BCBSLA of the requested protected health information.

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the Privacy Office at 5525 Reitz Avenue, Baton Rouge, LA 70809-3802. Revocation of this authorization will *not* affect any action taken in reliance on this authorization before we receive your written notice of revocation.

SECTION E: INDIVIDUAL’S SIGNATURE

I, * _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

*Signature: _____ *Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative’s Name: _____
 Relationship to Individual: _____

(A personal representative is a legal designation and generally refers to parent of an unemancipated minor, Legal Guardian, or holder of Power of Attorney.) Attach legal documentation of Legal Guardian or holder of Power of Attorney.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.