Louisiana

Do you want us to share your health information with someone?

Fill Out the Form to Permit Us to Use or Release Your Protected Health Information

By law, at Blue Cross and Blue Shield of Louisiana, we must safeguard your protected health information. *Protected health information* is any information in your medical record that can be used to identify you and that was created, used, or disclosed while providing a healthcare service. For instance, if you went to a doctor and the doctor diagnosed a disease, that information is protected.

Specifically, under the Health Insurance Portability and Accountability Act (often called HIPAA), health information such as diagnoses, treatment information, medical test results, and prescription information are protected health information. Also, national identification numbers and demographic information are protected. That means birth dates, phone numbers, email addresses, and Social Security numbers are also protected health information.

What Is the Purpose of This Form?

You may authorize Blue Cross to share your information with others by completing this form. Your choice will not affect your health plan or your benefits.

By filling out this form, you give us at Blue Cross and Blue Shield of Louisiana and our subsidiary, HMO Louisiana, Inc. permission to release your protected information to other people or organizations.

You should know that these people or organizations may not have to follow federal privacy laws. They may also share your information and federal laws may no longer protect it.

Generally, we use this form to release information for one time only. If you would like us to share your information with someone more frequently, fill out a form called *Name an Authorized Delegate.* For a copy of that form, go to www.bcbsla.com/forms-and-tools.

Where Should You Send this Form?

After the form has been completed, return it to the person or department that gave it to you or that asked you to fill it out. You may also mail it to us:

Privacy Office
Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029

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Blue Cross and Blue Shield of Louisiana is incorporated as Louisiana Health Service & Indemnity Company. HMO Louisiana, Inc. is a subsidiary of Blue Cross and Blue Shield of Louisiana. Both companies are independent licensees of the Blue Cross and Blue Shield Association.

Louisiana

I Allow Blue Cross to Use or Release Information About My Health

What you need to know

By filling out this form, you give Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. permission to release your protected health information to other people or organizations. You should know that we may give this information to people or organizations that do not follow federal privacy laws. They may also share your information and federal laws may no longer protect it.

You can choose whether or not we may release your information. Your choice will not affect your health plan or your benefits.

Who is the member?

Member's name As shown on the Blue Cross ID card					
Mailing address	Street				
	City		State		ZIP code
Daytime phone number	( ) -		**Email**		
Blue Cross ID number As shown on the ID card		OR	**Social Security number**	___ ___ ___ - ___ ___ - ___ ___ ___ ___	
Date of birth	___ /___ /_____ MM / DD / YYYY				

What type of protected health information may we use or release?

Reason or purpose for using or releasing information

Specific Reason or Purpose

This authorization...

- ❑ **Is ONLY for psychotherapy notes**. This authorization may not be used for any other type of protected information.
- ❑ **Includes records of alcohol or drug use disorder.** In our release, we will include this statement: *Federal regulation 42 CFR part 2 prohibits unauthorized disclosure of these records.*
- ❑ **Includes genetic information.** This authorization for use or release of genetic information shall be invalid if used for any purpose other than the described purpose for which the disclosure is made.

Specific and meaningful description of the protected health information that this authorization addresses

What kind of information will be used? How much?

Who is allowed to release the information?

Name or describe the people or organizations who will be allowed to release the information. Include Blue Cross in your list.

Person or organization 1:	Name				
	Street				
	City		State		ZIP code
Person or organization 2:	Name				
	Street				
	City		State		ZIP code
Person or organization 3:	Name				
	Street				
	City		State		ZIP code

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Who is allowed to receive and use the information?

Name or describe the people or organizations who will be allowed to receive and use the information.

Person or organization 1:

Name

Street

City | State | ZIP code

Person or organization 2:

Name

Street

City | State | ZIP code

Person or organization 3:

Name

Street

City | State | ZIP code

When will this permission end?

How long this authorization will last

This authorization will end:

❑ **On this date** ___ /___ /_____
MM / DD / YYYY

Note: Authorizations for the release of genetic information will end on this date or 60 days from the authorization date, whichever is less. (LAC 37:XXIII. Chapter 45 (Regulation 63))

OR

❑ **When this happens:**

The event or condition listed must relate to the person or to the purpose of the authorized use or release. It may last no longer than reasonably necessary to serve the purpose.

You can end this authorization at any time

Revoking this authorization will not affect any action we took before we received your notice.

To revoke this authorization:

❑ **Write to us at:** **Privacy Office**
Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, Louisiana 70898-9029

❑ **Call the Privacy Office at (225) 298-1751 for records of alcohol or drug use disorder only.**

Sign this form

After you sign the form, you may have a copy of it. If we have requested this form to be completed, we will provide a copy to you.

By signing below, you agree that you had full opportunity to read and think about the contents of this authorization.

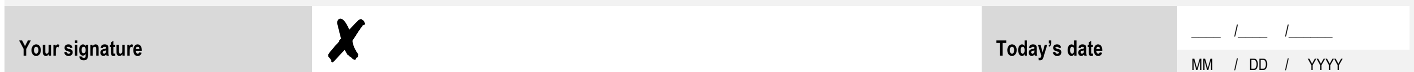
You understand that you are confirming that you authorize the use or release of your protected health information, as described in this form.

You are:

❑ **The member**

❑ **A representative.** My relationship to the member:

Your signature ✗ **Today's date** ___ /___ /_____
MM / DD / YYYY



Note to the department requesting or receiving this authorization:

Documentation requirement. Include this authorization in your department files and keep an electronic or hard copy for 10 years after the last effective date.

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