

Instructions for Completing the Member Authorization Form



If you have any questions, please feel free to call us at the customer service number on your member identification card.

Please read the following for help completing page one of the form.

PART A: MEMBER INFORMATION

This section applies to the member who is asking for the release of his or her information to another person or company.

- 1 Print your last name, first name, and middle initial
- 2 Write your date of birth in this format: mm/dd/yyyy. (If you were born on October 5, 1960, you would write 10/05/1960.)
- 3 Write your full street address, city, state, and ZIP code
- 4 Write your daytime phone number (including area code)
- 5 **Identification number**
You will find this number on your member identification card
- 6 **Group number**
You will find this number on your member identification card. If your identification card does not have a group number leave this blank.

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

- 7 Check the box that applies to you. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific.
- 8 If you check "Other," give the first and last name (if available), the name of the company (if applicable), and how they relate to you.

PART C: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release: all or just some.

- 9 For "all of your information," check the first box.
- 10 For "limited information," check the second box and the boxes that apply to you.
- 11 Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.

Empire
BLUECROSS BLUESHIELD

Member Authorization Form

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

PART A: MEMBER INFORMATION

Member last name	Member first name	Middle initial	Member date of birth
Member street address	City	State	ZIP code
Daytime telephone number (with area code)	Identification number (see identification card)	Group number (see identification card)	

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please check each box that applies and enter first and last name.

<input type="checkbox"/> My spouse (enter first and last name)	<input type="checkbox"/> My parents (if you are over 18 - enter first and last name(s))
<input type="checkbox"/> My domestic partner (enter first and last name)	<input type="checkbox"/> My insurance broker or agent (enter the name of the company and first and last name, if you have it)
<input type="checkbox"/> My adult children (enter first and last name(s))	<input type="checkbox"/> Other (enter first and last name (if you have it), name of company, and how it's related to you)

PART C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be used or released by Empire BlueCross BlueShield on my behalf (check only one box):

All my information. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

Only limited information may be released (check all boxes below that apply to you).

<input type="checkbox"/> Appeal	<input type="checkbox"/> Eligibility and enrollment	<input type="checkbox"/> Referral
<input type="checkbox"/> Benefits and coverage	<input type="checkbox"/> Financial	<input type="checkbox"/> Treatment
<input type="checkbox"/> Billing	<input type="checkbox"/> Medical records	<input type="checkbox"/> Dental
<input type="checkbox"/> Claims and payment	<input type="checkbox"/> Doctor and hospital	<input type="checkbox"/> Vision
<input type="checkbox"/> Diagnosis (name of illness or condition) and procedure (treatment)	<input type="checkbox"/> Pre-certification and pre-authorization (for treatment approvals)	<input type="checkbox"/> Pharmacy
		<input type="checkbox"/> Other: _____

I also approve the release of the following types of sensitive information by Empire BlueCross BlueShield (check all boxes that apply to you):

All sensitive information

OR

Just information about topics checked below

<input type="checkbox"/> Abortion	<input type="checkbox"/> Genetic testing	<input type="checkbox"/> Mental health
<input type="checkbox"/> Abuse (sexual/physical/mental)	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Sexually transmitted illness
<input type="checkbox"/> Alcohol/substance abuse **	<input type="checkbox"/> Maternity	<input type="checkbox"/> Other: _____

** I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described below in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

22940NYMENEBS 3/12 Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. 1 of 2

Please read the following for help completing page two of the form.

PART D: PURPOSE OF THIS APPROVAL

This section tells us the reason you've asked for the release of your information.

- 1 Check the first box to let us know to give out this information as shown on this form.
- 2 Check the second box for a specific reason. An example might be to settle a life insurance claim.

PART E: DATE YOUR APPROVAL EXPIRES

You have two choices of when you would like this approval to end.

- 3 Check the first box for the standard one-year that it will end.
- 4 Check the second box for an earlier date (other than one year), and give the date you wish this approval to end.

Your authorization/approval can't be granted for more than one year.

PART F: REVIEW AND APPROVAL

- 5 Sign your name and put the date on the form. Your name and signature *must* match the information in Part A.
- 6 If you are signing this form on behalf of another person, or if you have Power of Attorney for health care, or are a legal guardian/conservator you must do the following:

- o You must complete the Designated Legal Representative/Guardian section.
- o You must also provide us with a copy of the legal document showing that you are approved and include it with this form.

Examples of legal documents:

- o **Health Care, General or Durable Power of Attorney.** This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- o **Legal Guardianship.** This is when the court appoints someone to care for another person.
- o **Conservatorship.** This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- o **Executor of estate.** This type of document would be used when the person who is being represented has died.

PART D: PURPOSE OF THIS APPROVAL	
1 <input type="checkbox"/> To give out the information as shown on this form	
OR	
2 <input type="checkbox"/> For this reason(s):	
PART E: DATE YOUR APPROVAL EXPIRES	
If this document was not already withdrawn, this approval will end on the earliest of the following dates:	
3 <input type="checkbox"/> One year from the signature date in Part F	
OR	
4 <input type="checkbox"/> Earlier than one year and upon the date, event or condition described below	
PART F: REVIEW AND APPROVAL	
I have read the contents of this form. I understand, agree, and allow Empire BlueCross BlueShield to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Empire BlueCross BlueShield does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.	
I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Empire BlueCross BlueShield. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.	
Member signature or Designated Legal Representative/Guardian signature	Date
X	5
DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN	
6 If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:	
o A copy of a health care, general or Durable Power of Attorney.	
OR	
o A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.	
Please complete the following:	
Legal representative (print full name)	Legal relationship to member
Legal representative street address	City State ZIP code
Signature	Date
X	
Please return the completed form to: Empire BlueCross BlueShield P.O. Box 1407 Church Street Station New York, NY 10008-1407	
Be sure to keep a copy of this form for your records.	
FOR RECIPIENT OF SUBSTANCE ABUSE INFORMATION	
This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records 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.	
For internal use only:	Inquiry tracking number

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<input type="checkbox"/> My spouse (enter first and last name)	<input type="checkbox"/> My parents (if you are over 18 - enter first and last name[s])
<input type="checkbox"/> My domestic partner (enter first and last name)	<input type="checkbox"/> My insurance broker or agent (enter the name of the company and first and last name, if you have it)
<input type="checkbox"/> My adult children (enter first and last name[s])	<input type="checkbox"/> Other (enter first and last name [if you have it], name of company, and how it's related to you)

PART C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be used or released by Empire BlueCross BlueShield on my behalf (check only one box):

All my information. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

Only limited information may be released (check all boxes below that apply to you).

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Appeal | <input type="checkbox"/> Eligibility and enrollment | <input type="checkbox"/> Referral |
| <input type="checkbox"/> Benefits and coverage | <input type="checkbox"/> Financial | <input type="checkbox"/> Treatment |
| <input type="checkbox"/> Billing | <input type="checkbox"/> Medical records | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Claims and payment | <input type="checkbox"/> Doctor and hospital | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Diagnosis (name of illness or condition) and procedure (treatment) | <input type="checkbox"/> Pre-certification and pre-authorization (for treatment approvals) | <input type="checkbox"/> Pharmacy |
| | | <input type="checkbox"/> Other: _____ |

I also approve the release of the following types of sensitive information by Empire BlueCross BlueShield (check all boxes that apply to you):

All sensitive information

OR

Just information about topics checked below

- | | | |
|---|--|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Genetic testing | <input type="checkbox"/> Mental health |
| <input type="checkbox"/> Abuse (sexual/physical/mental) | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Sexually transmitted illness |
| <input type="checkbox"/> Alcohol/substance abuse ** | <input type="checkbox"/> Maternity | <input type="checkbox"/> Other: _____ |

** I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described below in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

PART D: PURPOSE OF THIS APPROVAL

To give out the information as shown on this form

OR

For this reason(s): _____

PART E: DATE YOUR APPROVAL EXPIRES

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

One year from the signature date in Part F

OR

Earlier than one year and upon the date, event or condition described below

PART F: REVIEW AND APPROVAL

I have read the contents of this form. I understand, agree, and allow Empire BlueCross BlueShield to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Empire BlueCross BlueShield does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Empire BlueCross BlueShield. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature X	Date
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DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)		Legal relationship to member		
Legal representative street address	City	State	ZIP code 	
Signature X		Date 		

Please return the completed form to:

Empire BlueCross BlueShield
P.O. Box 1407 Church Street Station
New York, NY 10008-1407

Be sure to keep a copy of this form for your records.

FOR RECIPIENT OF SUBSTANCE ABUSE INFORMATION

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFP 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.

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