BlueLincs
Blue Cross and Blue Shield of Oklahoma

A Wholly Owned Subsidiary of Blue Cross and Blue Shield of Oklahoma,
a Member of the Blue Cross and Blue Shield Association,
an Association of Independent Blue Cross and Blue Shield Plans.
® Registered Marks Blue Cross Blue Shield Association.

Authorization to Disclose Protected Health Information

Subscriber Medical ID #: _____
(Please provide your Soc. Sec. # if you have not been issued a Subscriber Medical ID #)

I. Individual (Name, telephone number, and date of birth of person authorizing disclosure):

Name: _____ Date of Birth: _____

Telephone #: (_____) _____

II. Authorization:

I request and authorize BlueLincs HMO to disclose my protected health information as described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Persons/Organizations authorized to receive your information	**Relationship**
_____	_____
_____	_____
_____	_____

III. Specific Description of Information to be Used or Disclosed (check one or more):

☐ Health Plan Benefit Information — Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).

☐ Claims Information — Includes information related to payment of your claims for services you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions, claim payment or denial reasons, etc.).

☐ Authorization Information — Includes information regarding precertification and authorization, including specific medical information related to requests and determinations.

☐ Premium Information — Includes information related to billing cycles, bank draft changes, etc.

☐ Services on [date(s)] — from: _____ to: _____
(Includes information related to services that occurred during the specific time frame)

☐ Services from (provider or supplier): _____
(Includes information related to services rendered by a specific provider or supplier)

☐ Other _____
(Specify other information authorized for disclosure if it is not listed in one of the categories above)

This Authorization CANNOT be used to disclose Psychotherapy Notes

PLEASE COMPLETE THE BACK OF THIS FORM

IV. Expiration and Revocation:

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed ☐ On the following date: _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

I acknowledge that, in accordance with state law, **the information authorized for disclosure may include information which may be considered a communicable or venereal disease, which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization.

X _____ _____

Signature Date

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents:

_____ _____

Personal Representative's Name Relationship to Individual

BEFORE RETURNING
YOU MAY WISH TO MAKE A COPY OF THIS SIGNED AUTHORIZATION FOR YOUR RECORDS

Mail your completed signed authorization to:

Member Advocacy Unit
BlueLincs HMO
P.O. Box 21128
Tulsa, OK 74121-1128

Internal or Third Party Use Only

Must be completed by a health plan, health care provider or third party **if** the authorization is requested:

The purpose of the use or disclosure _____

☐ At the Request of the Individual (If the authorization is at the request of Blue Cross and Blue Shield of Oklahoma, (and not the individual) then the ***purpose*** for the use or disclosure must be stated, and a ***copy*** of the signed authorization must be returned to the individual or representative.)