PREMERA | BLUE CROSS

Authorization for Release of Healthcare Information and Records

Instructions:

Fill out this form to allow us to share the member's personal information with the person or entity you name. Make sure you tell us:

1) Whom you want to receive the personal information
2) What types of information you want us to share
3) How the personal information is to be used

If you have questions about this form, please call the number listed on the back of your ID card.

Notice of Privacy Practices:

Our Notice of Privacy Practices describes how we use and disclose member personal information and members' rights concerning it. It can be found on our website at ***www.premera.com***. For a paper copy, please call Customer Service at 1-800-427-7272.

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION AND RECORDS

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Please fill out the information, below, and print clearly.

Member Name: (First/MI/Last) Date of Birth:

Subscriber Name: (First/MI/Last) Subscriber ID Number:

HEALTHCARE INFORMATION AND RECORDS TO BE RELEASED TO:

Name: Phone: ( ) -

Address: Fax: ( ) -

City: State: ZIP:

INFORMATION TO BE RELEASED: I allow Premera Blue Cross or any of its affiliates (the "Company"), to share the member's personal information with the person/entity listed, above.

I understand that the Company needs my written authorization to release any sensitive information. Sensitive information includes testing, diagnosis, procedures and/or treatment for alcohol and/or chemical dependency, reproductive health, sexually transmitted diseases (including HIV/AIDS), genetic information or psychiatric disorders/mental illness.

I allow the Company to only share information related to the box(es) checked, below.

- ☐ General Health Care (claims, billing, and eligibility information not related to one of the sensitive categories, below)
- ☐ Alcohol and/or Chemical Dependency
- ☐ Reproductive Health (including abortion)
- ☐ Other:
- ☐ Sexually Transmitted Diseases (HIV/AIDS)
- ☐ Psychiatric Disorders/Mental Illness
- ☐ Genetic Information (genetic information is not collected or used for underwriting or enrollment purposes)

PURPOSE FOR RELEASE:

- ☐ At the request of the Individual
- ☐ At the request of the Company for:
  - ☐ Research
  - ☐ Other:
- ☐ Other (please state specific date, specific time period, event or condition):

CANCELLING THIS RELEASE: I may change my mind and cancel this release at any time by writing the Company. After the Company gets my notice, the Company will cancel this release within five (5) business days. I understand that the Company may already have shared some or all of my information and that the Company will not be liable for any information already released.

DURATION OF RELEASE: This release lasts for twenty-four (24) months from the signature date, below, or as stated, above, under "Purpose for Release," unless I write to cancel it.

ADDITIONAL SHARING: The person or entity that receives the member's **i**nformation may be able to share it. State and federal privacy rules may no longer protect it.

NO CONDITION: This release is voluntary. It does not affect the member's enrollment in a health plan, eligibility for benefits, or payment of claims.

WHO MUST SIGN THIS FORM:

- For a member age 12 or younger: the parent or legal guardian
- For a member age 13 to 17, if no box, above, is checked other than "general health care": the parent or legal guardian
- For a member age 13 to 17, if any box, above, is checked other than "general health care": the member (unless a court with jurisdiction has deemed the member incapable of consenting to his or her own services and has appointed a legal guardian)
- For a member age 18 or older: the member (unless a court with jurisdiction has deemed the member incapable of consenting to his or her own services and has appointed a legal guardian)

*Sign your name: _____
*Print your name: _____
Date signed: _____

*If not the member, I am the ☐ Parent ☐ Legal Guardian ☐ Holder of Power of Attorney/Legal Representative
If you are the legal guardian or holder of a power of attorney/legal representative for the member, please attach legal documentation.

When completed, send this form to:

Premera Blue Cross, P.O. Box 91102, Seattle, WA 98111-9202

Fax: 425-918-5592

Please keep a copy of this request for your records.