BlueCross BlueShield Nebraska

PO Box 3248 • Omaha, NE 68180-0001

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Member ID: _____

Sub. Last Name: _____

Acronym: AUT

BLUE CROSS BLUE SHIELD OF NEBRASKA OFFICE USE ONLY

This form authorizes Blue Cross Blue Shield of Nebraska (BCBSNE) to release your Protected Health Information (PHI). Complete this form to authorize BCBSNE to disclose your PHI to another person or organization, such as your spouse. PHI is information about you that may identify you and relates to your past, present or future physical or mental health or condition and related health services. Please print clearly in blue or black ink.

SECTION A: Individual authorizing release of PHI

YOUR NAME: _____

YOUR PHONE NUMBER: (Day) _____

(Evening) _____

YOUR MEMBER ID NUMBER (AS SHOWN ON YOUR BCBSNE ID CARD)

☐☐☐ ☐☐☐☐☐☐☐☐☐

(PREFIX) (NUMBERS)

YOUR ADDRESS: _____ _____

Street Apartment #

_____ _____ _____

City State ZIP

SECTION B: Description of authorization

- I authorize BCBSNE to release my PHI as described in this authorization. I understand that my PHI may include, but is not limited to, the following: medical records, emergency care records, billing statements, Explanation of Benefits, diagnostic imaging reports, transcribed hospital reports, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization.
- I further understand that my PHI may include information related to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/ AIDS, prescription medication, pregnancy/maternity, organ transplants, and chemical dependency (including alcohol and drug treatment).
- I further understand that this authorization applies to **ALL** PHI, regardless of when created, obtained, or maintained by BCBSNE, unless stated differently here (if none, please leave blank):

_____

SECTION C: Persons/Organizations authorized to receive my PHI

Please tell us who you are authorizing to receive your PHI by completing the table below.

- For “Person’s Relationship to You,” please give a general description such as “husband” or “attorney.”
- The "End Date" is the date this authorization will end. If you do not want this authorization to end on a specific date, please check the "Upon Disenrollment" box. If you leave both the "End Date" AND "Upon Disenrollment" boxes blank, this authorization will remain valid until your disenrollment from your health plan* or for a period of six months from the date of your death. If your coverage is already terminated, you MUST provide us with a future "End Date."
- Certain changes to your health plan (e.g., changing to another employer that provides a BCBSNE health plan) may cause a disenrollment event without interrupting your coverage. If there is no material change to your coverage, this authorization may continue to be valid under the member ID number listed on this form.

Individuals Authorized to Receive Your PHI

Name of Person to Receive PHI	Person’s Relationship to You	Address	ZIP Code	Telephone Number	End Date	Upon Disenrollment
						☐
						☐
						☐

Purpose for which release is to be made (this section may be left blank if you do not wish to specify a reason):

_____

SECTION D: Terms and conditions of this authorization

I understand that I may refuse to sign this authorization. I understand that BCBSNE may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I also understand that if the person(s)/organization(s) authorized to receive my PHI is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I further understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization.

Please contact BCBSNE at the address or telephone number listed below to obtain the standard authorization revocation form. Unless revoked earlier, this authorization will end on the date specified above or upon my disenrollment from the health plan (as defined in Section C).

SECTION E: Your signature

Signature of Individual: _____ Date: _____

If signed by a personal representative on behalf of the individual, please complete the following:

Personal Representative Name: _____

Relationship to the member (check one of the following):

☐ **Parent:**

As the parent of the minor child, you are authorized to obtain protected health information (PHI). If you want to authorize another person to receive PHI on this minor child, you must check this box and write your name in the personal representative field above.

☐ **Legal Guardian, Conservator or Executor:**

Please attach legal documentation showing that you are the legal guardian, conservator or executor.

☐ **Durable Power of Attorney:**

Please attach legal documentation showing that you hold a Durable Power of Attorney.

Please return the completed and signed form in the enclosed postage-paid envelope, OR to the following address:

Blue Cross Blue Shield of Nebraska
Attention: Privacy Office
P.O. Box 3248
Omaha, NE 68180-0001

Fax Number: 402-392-4153
E-mail: ContactUs@NebraskaBlue.com (scan signed document to e-mail)

If you have questions, need additional information or assistance in completing this form, please contact us at the above address or by calling 877-258-3888.