AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

Member Name: _____ Member SSN (optional): _____

Member Date of Birth: _____ Member Health Plan ID: _____

At the request of _____, the Member or
Print Name of Individual or Entity Receiving Protected Health Information
his/her Authorized Personal Representative (APR) hereby authorizes Blue Advantage to disclose protected health information.

The specific information Blue Advantage is authorized to disclose includes (Initial all that apply):

_____ Eligibility information, such as enrollment forms, change forms, etc.

_____ Clinical and medical records and data, including copies of (a) hospital records, x-rays, x-ray readings and reports, laboratory records and reports, all tests of any type or character and reports pertaining to hospitalization, history, condition, treatment, diagnosis, prognosis, etiology or expenses; (b) medical records, including Member's record cards, x-rays, x-ray readings and reports, laboratory records and statements of charges, and any and all copies of records pertaining to medical care, history, condition, treatment, diagnosis, prognosis, etiology or expenses; (c) correspondence and/or memoranda prepared by a healthcare provider or his/her office pertaining to medical care, history, condition, treatment, diagnosis, prognosis, etiology or expenses.

_____ Excluding psychotherapy notes if present

_____ Including psychotherapy notes if present

_____ Payment data, such as explanation of benefits and premium information

_____ Other information as specified: _____

This information is being disclosed by Blue Advantage for the purpose of:

_____ Legal proceedings including custody, settlement of deceased estate, litigation

_____ Subscriber/Member request for release to Authorized Personal Representative to handle Subscriber/Member's affairs

_____ Other information as specified: _____

Member hereby acknowledges that he/she understands that treatment, payment, enrollment in the health plan, or eligibility for benefits, is not conditioned on his/her signing of this Authorization (45 CFR §§164.508(b)(5) and164.508(c)(2)). However, Blue Advantage may condition the provision of research-related treatment on Member's signing of this Authorization for the use and disclosure of protected health information created for research that includes treatment of the individual. Member may refuse to sign this Authorization if he/she so chooses. This Authorization is for the release of medical records and does authorize verbal communications by the healthcare provider to the person(s) or entity(ies) listed above.

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

At all times, Member retains the right to revoke this Authorization, except if the Authorization was obtained as a condition of obtaining insurance coverage. Such revocation must be submitted to Blue Advantage in writing. The revocation shall be effective except to the extent that Blue Advantage has already used or disclosed information in reliance on the Authorization. Member may revoke this Authorization by submitting a notice in writing to Blue Advantage at P.O. Box 98004, Baton Rouge, LA 70898-9004 (45 CFR §§164.508(b)(5) and164.508(c)(2)).

The Member has been informed and understands that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of such information, and, at that point, the information may no longer be protected under the terms of this Authorization (45 CFR §164.508(c)(2)).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM A BLUE ADVANTAGE MEMBER OR I AM AUTHORIZED TO ACT ON BEHALF OF THE MEMBER TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

Blue Advantage may use or disclose such protected health information only until this authorization is revoked in writing.

Date: _____ Time: _____AM/PM

_____
Signature of Member

_____
Please Print Name

_____
Signature of Witness

_____
Member's Authorized Personal Representative*

_____
Please Print Name

_____
Please Print Name

*Please explain Authorized Personal Representative's relationship to Member and include a description of Authorized Personal Representative's authority to act on behalf of Member. If applicable, attach any relevant legal documentation.