BlueCross BlueShield of Mississippi

Complete each Section and sign this form.
Return by fax to (601) 664-4093 or mail to:

Blue Cross & Blue Shield of Mississippi
ATTN: Privacy Office
P.O. Box 1043
Jackson, MS 39215

BLUE CROSS AND BLUE SHIELD OF MISSISSIPPI, A MUTUAL INSURANCE COMPANY

GENERAL AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

SECTION A:

Name of Individual whose protected health information is being authorized for disclosure: ____________________

____

Address: ____

Telephone Number: ________________________ Member I.D. Number: ________________________
(as it appears on I.D. card)

SECTION B: The use and/or disclosure being authorized.

B.1. Protected Health Information to Be Disclosed and/or Used: Specifically and meaningfully describe the protected health information you are authorizing to be disclosed by Blue Cross & Blue Shield of Mississippi (BCBSMS): **(choose one)**

☐ ALL information relating to the provision or payment of healthcare benefits or services (examples: claims, EOBs, benefits, membership information, premium or billing information, etc.,), **OR**;

☐ Only the specific information described here: ____

____

____

☐ Check this box if this authorization applies ONLY to psychotherapy notes. ***NOTE - If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information. Use a separate form for other protected health information.***

B.2. Entities Authorized to Disclose: By properly completing and signing this authorization form, you are authorizing **BCBSMS** to disclose the protected health information described above (see B.1.) to the entities described below (see B.3.).

B.3. Entities Authorized to Receive and Use: **Name or specifically identify** the persons and/or organizations (or the classes of persons and/or organizations) that you are authorizing to receive protected health information described above (see B.1.) from BCBSMS:

____ ____

____ ____

B.4. Purpose of this Authorization: **(choose one)**

☐ At the request of the individual (or the individual's personal representative)

☐ For the following purposes: ____

____

BCBS 16700 Rev. 7/05

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, is an independent licensee of the Blue Cross and Blue Shield Association.

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan or eligibility for benefits on receiving this authorization.

Effect of Granting this Authorization: The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION C: Expiration and revocation.

Expiration: This authorization will expire **(choose one)**:

☐ After I am no longer enrolled in a Blue Cross and Blue Shield of Mississippi, A Mutual Insurance Company health benefits plan (NOTE: If none of these boxes is checked, we will assume the authorization is effective so long as you are enrolled in a Blue Cross and Blue Shield of Mississippi health benefits plan)

☐ On _____/_____/_________

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

____

____

Right to Revoke: You may revoke this authorization at any time by giving written notice of your revocation to the Contact Office listed below. Revocation of this authorization will not affect any action the discloser or recipient of the protected health information took in reliance on this authorization before the discloser or recipient received your written notice of revocation.

To revoke your authorization for BCBSMS to disclose the protected health information, you may write to:

Contact Office: Blue Cross and Blue Shield of Mississippi
Attn: Privacy Office
P.O. Box 1043
Jackson, MS 39215-1043

INDIVIDUAL'S SIGNATURE

I, ____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Signature: ____ Date: ______________________

If this authorization is by a personal representative on behalf of the individual (with the exception of a parent requesting on behalf of a minor child), the following information must be provided and the request must be accompanied by written documentation of the requester's authority to act on behalf of the individual.

Personal Representative's Name: ____

Relationship to Individual: ____

YOU MAY WISH TO MAKE A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS AFTER YOU SIGN IT AND BEFORE RETURNING IT.

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