Authorization for Release of Protected Health Information (PHI)

BlueCross BlueShield Kansas

There are times when you may want your PHI released to other individuals like a spouse, guardian, or other family member. Because your records are confidential, we will need your signed consent to release your PHI. Release of PHI includes both written records and verbal information.

Section 1 – Member who is giving consent

This form can only be used for one member. Please submit a separate form for each member.

Print Name

Enrollee ID (number on your card beginning with 1-3 letters)

Address

(_____) _____-_____
Phone Number

City

Email Address

State ZIP Code +4

Section 2 – Person or organization that may receive your information

Note: If information is shared with a person or organization that is not legally required to obey privacy laws, the information may be shared with others and no longer protected. Print first and last name for a person, and the most detailed name possible for an organization (for example, hospital name and department).

Print Name

Address

City

State ZIP Code +4

Section 3 – Protected health information to be shared (check one)

☐ Premium Information

☐ Claim Information

☐ Benefit Information

☐ Authorization of medical services

☐ Any and all information (including personal, health, demographic, claims, billing and medical records)

☐ Only limited information (please describe) _____

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Please continue on the next page.

Please check below if you would also like to include any of the following highly protected health information (known as super PHI):

☐ Substance abuse records (including alcoholism)

☐ AIDS or HIV treatment records

☐ Mental health services (does not include psychotherapy notes)

Section 4 – Expiration and cancellation

This permission will expire (check one box only):

☐ On this date (month, day and year, MM/DD/YYYY) _____

☐ When canceled, or upon my death

I understand that I can cancel this authorization at any time. To cancel this Authorization, please send a written statement to Blue Cross and Blue Shield of Kansas at PO BOX 261367, Plano, TX, 75026-1367 and state that you are revoking this Authorization. Please include a copy of the original Authorization if available. Otherwise, please include the name of the party receiving the protected health information and the date of the Authorization. You may also call the number listed on the back of your ID card to obtain the standard authorization revocation form. I understand that cancelation will not apply to information that has been released by this authorization.

Section 5 – Authorization and signature

I allow the use and disclosure of my protected health information as described above. This information is being released at my request. I understand that my treatment, payment, enrollment or eligibility for benefits does not depend on whether I sign this authorization.

_____ _____ / _____ / _____

Signature of Member Date Signed

Section 6 – Personal representative

If you are not the member, please sign and date below then check the box that describes your relationship to the member.
Please attach proof of your relationship to the member (e.g., power of attorney, personal representative documentation, etc.).

_____ _____ / _____ / _____

Signature of Personal Representative Date Signed

_____ _____

Printed Name of Personal Representative Personal Representative's Email

☐ Legal guardian ☐ Power of attorney ☐ Executor ☐ Other

IMPORTANT: Please read the form over carefully and be sure you have included all necessary information. We cannot take additional information by phone, fax or email. If information is missing, we will have to contact you and request a new form.

Mail completed consent form to:

BCBSKS Member Correspondence
P.O. Box 211355
Eagan, MN 55121

or fax to: 800-426-6535

For additional assistance completing this form, please call Customer service at 800-222-7645 (TTY 711).
ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 800-222-7645 (TTY 711).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-222-7645 (TTY: 711).