Member's Authorization for Release of Information

Please use this form to authorize Blue Cross and Blue Shield of Massachusetts, Inc. (BCBSMA) to send specific information to a specific person for a specific time, when that release is not otherwise allowed by law. Use of this form does not provide the recipient with unlimited access to the Member's information.

The member named below should be the person signing this authorization and requesting the release of information. If the member is a minor, a parent or legal guardian must sign. If the member is unable to sign for any other reason, a legal representative must sign the authorization and submit documentation to verify the authority to sign.

Member's Name: _____ Member's ID#: _____ Date of Birth: _____

Address: _____ Daytime Phone Number: _____

_____

I authorize BCBSMA to disclose claims and medical information in its files as follows:

You must circle one answer for each option listed (circle "No" if not applicable)

I authorize release …	*of these records*
Yes No	HIV testing and/or AIDS diagnosis or treatment
Yes No	Mental health
As directed:	Claims and medical information listed here (please describe in detail):

_____

Name of person or entity to receive information: _____

Address: _____

_____

This authorization expires _____(To be completed by member/representative, but not to exceed one year. If not specified, expiration is one year from the date of signature). It is completed at my own request and is not a condition of enrollment or benefits. I may revoke this authorization at any time by notifying BCBSMA in writing. I understand that a revocation will not apply to information already released while this authorization was in effect. I understand that once information has been released according to these instructions, BCBSMA will not be able to limit the recipient's use or disclosure of the information, and privacy laws may no longer protect the information. I may receive a copy of this authorization and agree that a photocopy is as valid as the original.

Signature: _____ Print name: _____ Date: _____

If not the member, please state your relationship to the member (for example, "parent") here:

Please return this form to the BCBSMA Representative who supplied it to you, or call the toll-free number on your ID card for additional assistance.