Authorization for the Use or Disclosure of Health Information

blue california

A. Use this form to authorize Blue Shield of California, Blue Shield of California Life & Health Insurance Company, and their business associates (collectively "Blue Shield") to use or to disclose your health information to another person or organization.

1. Person whose information is to be disclosed (the "member").

Member name and address:

Subscriber ID number:	Date of birth:

2. Who is authorized to receive the member's information (the "recipient")?

Recipient's name and address:

Recipient's relationship to the member:

3. What information may be disclosed to the recipient? (Check one)

☐ **Any or all information Blue Shield maintains.** This may include information relating to the member's medical care, diagnosis, providers, insurance or benefit claims/payments, and/or financial/billing information. *This does not include sensitive information unless specifically approved below.*

☐ **Only the following information, or types of information, Blue Shield maintains (specify):**

4. Is the recipient authorized to receive sensitive information?

☐ **NO – PROCEED TO SECTION 5**

☐ **YES – Complete EITHER (a) or (b) below – you may not select both. I specifically authorize the recipient to receive:**

a. ☐ Psychotherapy notes – ***If you check this box, you may not check any of the other boxes in section b. below.*** *An authorization for the release of psychotherapy notes may not be combined with an authorization for disclosure of any other type of Information.* **PROCEED TO SECTION 5.**

b. ☐ Complete this section **ONLY IF** you did not check box 4.a. above, and you wish to authorize disclosure of any of the following types of sensitive information (check all that apply):

☐ Abortion	☐ Alcohol/substance use disorder	☐ Genetic information
☐ HIV/AIDS	☐ Mental health	☐ Pregnancy
☐ Sexual, physical, or mental abuse	☐ Sexually transmitted illness	

Note to parents/legal guardians of minors age 12 or older: You may be unable to obtain or authorize the use or disclosure of certain types of sensitive information about the minor without the minor's own written authorization. This may include the types of sensitive information listed above as well as information regarding infectious diseases, rape/sexual assault, and certain outpatient mental health counseling/treatment. If the minor is age 17 or older, disclosure of information relating to domestic violence and blood donations also requires the minor's authorization.

5. What is the purpose of the requested use or disclosure of information?

☐ The Information is about me and is to be used or disclosed at my request

☐ To resolve a claim dispute or appeal

☐ Other (specify):

B. Expiration and revocation

This authorization will remain in effect for one year from the date you sign it (below) unless a different date is specified here: _____

You have the right to revoke this authorization at any time by notifying Blue Shield in writing. *Revoking this authorization will not affect information we use or disclose before we receive your revocation request.* If this authorization is given by a parent or legal guardian on behalf of a minor, it will expire on the minor's 18th birthday.

C. Signature

I have read this form and I understand and agree to its terms. I direct Blue Shield to use or to disclose the information to the noted recipient as directed above. I understand that once my information is disclosed, it could be re-disclosed by the recipient and may no longer be protected by privacy laws, including the federal Health Insurance Portability and Accountability Act of 1996.

I understand that Blue Shield may not condition payment, enrollment in a health plan, or eligibility for benefits on whether I sign this authorization.

Signature

Date

Print name

D. Personal or legal representatives or guardians

If this form is signed by someone other than the member or the parent of a minor, such as a personal/legal representative, guardian, or executor, **you must also submit legal documentation** showing your authority to act on behalf of the member (or the member's estate) to authorize the use or disclosure of the member's health Information. Such documentation may include, for example: 1) Durable Health Care Power of Attorney; 2) current, valid documentation of court-ordered guardianship; or 3) other valid legal documentation showing your authority to act on behalf of the member (or the member's estate).

Please also complete the following:

Representative's name (print):

Relationship to member:

Type of documentation submitted:

Keep a copy of this authorization for your records.

Return the completed and signed authorization form to:

CalPERS Strategic Health Operations Division
Health Appeal Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953