Authorization for Release of Protected Health Information (PHI)

BlueCross BlueShield of Kansas

There are times when you may want your PHI released to other individuals like a spouse, parent, 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.

Parents/Guardians: We want to be able to speak with you on behalf of your dependent child (over the age of 18 or between ages 14-18 for certain diagnosis) about their PHI. In order to do this, we are required to have their written consent.

If you want to share your PHI with someone else, please complete all sections carefully and return to Blue Cross and Blue Shield of Kansas (BCBSKS). This form is available online at www.bcbsks.com.

Section 1 – Person Authorizing Release

First Name
_____

Last Name
_____

Member Identification Number
_____

_____ _____ _____
Date of Birth

Residential Address
_____

City
_____

_____ _____ _____
State   ZIP Code   +4

Mailing Address (if different from residential address)
_____

City
_____

_____ _____ _____
State   ZIP Code   +4

I authorize BCBSKS to release (check one box):

☐ All information by all channels (including: telephone, web and written) about eligibility, enrollment, underwriting, premiums, plan benefits, claims, correspondence to or from BCBSKS and prior authorization or determinations for services provided by any physician or hospital.

☐ All documents, records, and other information (excluding psychotherapy notes) from any physician or hospital including information regarding alcohol and substance abuse.

☐ Documents, records, and other information to appeal a BCBSKS decision regarding my claim. May include medical records from my health care providers (excluding psychotherapy notes) and information regarding alcohol and substance abuse.*

☐ All documents, records, and other information from the following providers only:

_____

_____

_____

*** Important:** Submission of this form does not constitute an appeal.

Pertaining to this time period (check one box):

☐ Any or all dates.

☐ Range of dates.

From: _____ _____ _____ to _____ _____ _____
       MM   DD   YYYY   MM   DD   YYYY

☐ Specific date: _____ _____ _____
               MM   DD   YYYY

This release of information is for the specific purpose of (check one box):

☐ Assistance with a health plan.

☐ Other (be specific):

_____

_____

_____

Section 2 – Release of Protected Health Information (PHI)

Release my PHI to the following people:

_____
First Name

_____
Last Name

_____
Organization Name

_____ _____ _____   _____ _____ _____
Phone Number   Date of Birth

_____
First Name

_____
Last Name

_____
Organization Name

_____ _____ _____   _____ _____ _____
Phone Number   Date of Birth

_____
First Name

_____
Last Name

_____
Organization Name

_____ _____ _____   _____ _____ _____
Phone Number   Date of Birth

Dependent child authorization (under age 18):

☐   I authorize the release of PHI for my dependent(s) listed below:

_____

_____

_____

Release my dependents' PHI to the following people:

_____
First Name

_____
Last Name

_____
Organization Name

_____ _____ _____   _____ _____ _____
Phone Number   Date of Birth

_____
First Name

_____
Last Name

_____
Organization Name

_____ _____ _____   _____ _____ _____
Phone Number   Date of Birth

Section 3 – Authorization

I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations unless the information being disclosed is protected by federal alcohol and substance abuse regulation (FASAR). I understand that BCBSKS does not condition payment, enrollment, or eligibility for benefits on whether I sign this authorization. This authorization is valid until the termination of my health coverage with BCBSKS, dependents reach the age of 18, or until such time as written revocation has been received by BCBSKS.

In addition, I understand that I may revoke this authorization at any time by notifying BCBSKS in writing and that revocation of this authorization will not affect any action taken in reliance of this authorization before the written revocation was received. **If signing authorization as Power of Attorney, Power of Attorney for Health Care or Guardian/Conservator, a copy of the legal document must accompany this form.**

Your signature required

_____   _____ _____ _____
Applicant   Date Signed

When completed, please mail to:

Blue Cross and Blue Shield of Kansas
1133 SW Topeka Blvd., Topeka, KS 66629-0001

Note: Please keep a copy of this form for your files.

Internal Use Only

Return to _____

Mail stop _____