# AUTHORIZATION
# FOR RELEASE OF PROTECTED HEALTH INFORMATION
# FOR CONTINUITY OF CARE

I authorize the use and disclosure of my protected health information as described below.

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution, pharmacy or other medical caregiver that has treated me or provided medical services or supplies to me to disclose my protected health information to **Blue Cross and Blue Shield of North Carolina ("BCBSNC").**

The protected health information that may be used and disclosed is as follows:

**Medical records or any information concerning my current or past health status or treatment received from my medical care providers.**

I understand that BCBSNC will use and disclose my protected health information for the following purpose: **To coordinate continuity of medical care.**

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that BCBSNC will not condition the provision of health plan benefits on this authorization.

I understand that I may revoke this authorization at any time by sending a written notification addressed to: **Dental Blue Select, P. O. Box 2400, Winston-Salem, NC 27102**, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that BCBSNC already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in BCBSNC and, by law, BCBSNC has a right to contest the coverage.

This authorization expires 30 months from the date of signature.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

**Return this Authorization Form to:**
**Dental Blue Select**
**P.O. Box 2400**
**Winston-Salem, NC 27102**
**Fax: 336-714-1445**

***BCBSNC WILL PROVIDE PATIENT WITH A COPY OF THIS AUTHORIZATION***