

You may give Blue Cross Blue Shield of North Carolina (Blue Cross NC) written authorization to disclose your Protected Health Information (PHI) to anyone that you designate and for any purpose. If you want to authorize a person or entity to receive your PHI upon their request, please provide the information below. Completion of this form is not a condition or requirement of coverage and will not change the way that Blue Cross NC communicates with you. For example, we will continue to send Explanation of Benefits (EOB) statements to you upon request. However, if your adult child calls Blue Cross NC to inquire about you, your Protected Health Information will not be shared with your adult child unless you have given Blue Cross NC permission to do so by completion of this form.

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

**Please Print:**

Member's Name: \_\_\_\_\_

Member's Date of Birth:   /   /     Blue Cross NC ID Number: \_\_\_\_\_  
MONTH DAY YEAR

**At my request, I authorize Blue Cross NC to disclose my Protected Health Information (PHI) to:**  
 (If you choose, you may designate more than one person. However, you must fill out one form per person.)

Name/Entity: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to Member: \_\_\_\_\_

**The purpose of this disclosure is:**

To assist me with my health plan     To coordinate and manage my health     Other: \_\_\_\_\_

**We request that you provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: a) your ID number, b) your date of birth, and c) your address.**

**I authorize Blue Cross NC to disclose only the following Protected Health Information to the person/entity designated above.** (Check all that apply.)

- Any information requested
- All claims information
- Premium payment information
- Benefit information
- Enrollment information
- Explanation of Benefits information
- All services from a specific health care provider (list provider's name): \_\_\_\_\_
- Other (Please list specific PHI): \_\_\_\_\_

If applicable, this information may contain sensitive data, including data related to treatment of sexually transmitted or communicable diseases, HIV/AIDS, mental and behavioral health (except psychotherapy notes), genetic testing and termination of pregnancy.

**If applicable, I authorize Blue Cross NC to release alcohol/substance abuse information related to the above request.**     Yes     No

**I want the designated person/entity to have access to my PHI until my policy expires OR until the specified date of:**   /   /      
MONTH DAY YEAR

I understand that I may revoke this authorization at any time by giving Blue Cross NC written notice mailed to the address provided. However, if I revoke this authorization, I also understand that the revocation will not affect any action Blue Cross NC took while this authorization was valid before Blue Cross NC received my written notice of revocation.

I also understand that I do not have to authorize anyone to receive my PHI as a condition or requirement for coverage by Blue Cross NC.

I also understand that if the persons or entities I have authorized to receive my PHI are not health plans, covered health care providers, or health care clearing houses subject to the Health Insurance Portability and Accountability Act (HIPAA), or other federal health information privacy laws, they may further disclose my PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

However, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

\_\_\_\_\_  
Signature of Member: Date  
[ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ]  
MONTH DAY YEAR

**OR**

\_\_\_\_\_  
Signature of Personal Representative: Date  
[ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ]  
MONTH DAY YEAR

**If signed by a Personal Representative, please:**

a) Print your full name: \_\_\_\_\_

**AND**

b) Describe your authority to act for the member: \_\_\_\_\_  
(e.g., durable power of attorney, court order, parent of minor child, etc.)

**AND**

c) Attach the legal document naming you as the personal representative when you return this form.

**Note:** We will consider the effective date of this authorization to be the date we enter this authorization into our computer system, typically 5 days following receipt. If you would like this authorization to become effective on a date after Blue Cross NC enters the authorization into its system, please provide the date here:

[ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ]  
MONTH DAY YEAR

**RETURN THIS AUTHORIZATION TO:  
Attention: Data Operations  
Blue Cross and Blue Shield of North Carolina  
PO Box 2291  
Durham, NC 27702**

Blue Cross and Blue Shield of North Carolina is an HMO, PPO and PDP plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.

## **Non-Discrimination and Accessibility Notice**

### **Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides:**

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified interpreters and/or written information in other formats (large print, accessible electronic formats, etc.)
- Free language services to people whose primary language is not English, such as: qualified interpreters and/or information written in other languages

If you need these services, call the Customer Service or TTY number on the back of your member ID card.

If you believe that Blue Cross NC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

**Blue Cross NC, P.O. Box 2291, Durham, NC 27702**  
**Attention: Civil Rights Coordinator-Privacy,**  
**Ethics & Corporate Policy Office**  
**Call: 919-765-1663, 1-888-291-1783 (TTY)**  
**Fax: 919-287-5613**  
**E-mail: [civilrightscordinator@bcbsnc.com](mailto:civilrightscordinator@bcbsnc.com)**

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

**Online: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>**  
**Mail: U.S. Department of Health & Human Services**  
**200 Independence Avenue, SW Room 509F**  
**HHH Building Washington, D.C., 20201**  
**Call: 1-800-368-1019, 1-800-537-7697 (TDD)**  
**Complaint forms are available online at:**  
**<http://www.hhs.gov/civil-rights/filing-a-complaint/index.html>**

This notice and/or attachments may have important information about your application or coverage through Blue Cross NC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. If you need these services, call the Customer Service or TTY number on the back of your member ID card.

### **Discrimination is Against the Law**

Blue Cross NC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Blue Cross NC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

