

Authorization for Disclosure of Health Information

(1) I hereby authorize _____ to
(Highmark Blue Cross Blue Shield or its subsidiary, affiliate, business associate, etc. (hereinafter "Highmark Blue Cross Blue Shield"))

release/disclose the following information of:

Patient/Member Name

Date of Birth

Address

Identification Number

Telephone

The records to be disclosed cover the following period(s):

From (date)

To (date)

From (date)

To (date)

(2) Check if this authorization is for psychotherapy notes.

<If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information.>

(3) Information to be disclosed (Please check only that which applies.):

Designated Record Set: (Please check only that which applies.)

Enrollment Information

Claims Information

Payment Information

Managed Care Information (Pre-certification, 2nd Opinions, Treatment Plans, Care Coordination, Case Management, etc.)

AND/OR

Pharmaceutical information Discharge summary History and physical examination

Consultation reports Progress notes Laboratory tests

X-ray reports Explanation of Benefits Complete health record(s)

Other (please specify):

I understand that this will include information relating to (check if applicable):

Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)

Mental health care

Sexually transmitted disease

Treatment for alcohol and/or drug abuse

Other (please specify)

(4) This information is to be dedicated to _____ by Highmark Inc.
[organization or provider]

For the purpose of _____
[state purpose]

(5) I understand that I may revoke this authorization at any time by giving written notice of my revocation to _____ . I understand this revocation of this authorization will **not** affect any action Highmark Inc. or its subsidiaries, affiliates, business associates, etc. took in reliance on this authorization before it received my written notice of revocation. I also understand that without my written authorization, Highmark may not use or disclose my health information for any reason except those described in Highmark’s Notice of Privacy Policies and Practices. Unless otherwise revoked, this authorization will expire on the following date, event or circumstance.

[insert date, event, or circumstance]

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that Highmark may condition my enrollment or eligibility for benefits on my signing of this authorization (other than for psychotherapy notes), before Highmark enrolls me, to allow Highmark to obtain protected health information from another covered entity to determine my eligibility or enrollment or Highmark’s underwriting or risk rating.

I understand that Highmark may condition payment of a claim for specified benefits on my signing of this authorization (other than for psychotherapy notes) to allow other covered entities to disclose protected health information to Highmark that Highmark needs to determine payment of my claim.

Highmark Inc., its subsidiaries, affiliates, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed (Patient/Member)

Date

(Personal Representative) (Include a description of such representative’s authority to act for the patient/member)

Date

You are entitled to a copy of this authorization after you sign it.