MEMBER AUTHORIZATION

Please Print Clearly. Use Black Ink Only

Purpose: This form is used to authorize Blue Cross and Blue Shield of Georgia (BCBSGA) to use or disclose your Protected Health Information (PHI) to the individual(s) or class(es) of persons (organizations) you designate and for your authorized representative to disclose PHI to BCBSGA, for the purposes stated on the completed form.

SECTION A: Individual Authorizing Use and/or Disclosure - Complete information as it appears on member ID card. If you have more than one Member ID or Group Number, a separate form must be completed for each.

Last Name:__________________________ First Name: ___________________________ MI.: ___ Suffix: _____

Address: ____

Telephone: ( ) _______________________ Fax: ( ) ______________________________________

Group Number: ________________________Group Name:____

Member ID Number: ____

If this authorization is for psychotherapy notes, you must complete an authorization for any other type of PHI.

SECTION B: The Use and/or Disclosure Being Authorized

PHI to be Used and/or Disclosed: **{Specifically describe the PHI to be used and/or disclosed}**

____

____

Entities or Persons Authorized to Use or Disclose: **{Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including BCBSGA, who are authorized to make use of and/or to disclose the PHI described above}**

____ ____

____ ____

Entities or Persons Authorized to Receive: **{Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including BCBSGA, who are authorized to receive, and subsequently use and/or disclose the PHI described above}**

____ ____

____ ____

Purpose of this Authorization:

☐ At request of individual

☐ For the following purposes:

____

____

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of Granting this Authorization: The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

Member ID Number__________________

SECTION C: Expiration and Revocation

Expiration: This authorization will expire (complete only one):

☐ On _____/_____/_________
(mm) (dd) (yyyy)

☐ On occurrence of the following event (i.e. upon the end of my coverage with BCBSGA),which must relate to the individual or to the purpose of the use and/or disclosure being authorized:

____

____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: **Blue Cross and Blue Shield of Georgia**

Telephone: **Call the Customer Service number listed on your member ID card**

Please refer to the bottom of the page for mailing address and fax number.

SECTION D: Individual's Signature

I, ____, have had full opportunity to read and consider the
(Print Member Name)
contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Member Signature: ____ Date: ________________________

If this form is signed by a legal representative/guardian on behalf of the individual, please complete the following:

Legal Representative's Name: ____

Signature: ____ Date: ________________________

Relationship to Individual: ____

Please Keep a Copy of this Request for your Records

Forms cannot be submitted by email. Please return the completed form:

BY FAX to: 404-842-8040

Or

BY MAIL to: Blue Cross and Blue Shield of Georgia, Attn. Membership & Billing Department, Mail Code G00502, P.O. Box 4445, Atlanta, GA 30326

FAILURE TO PROVIDE ALL NECESSARY INFORMATION WILL RESULT IN THE FORM BEING RETURNED TO YOU