INSTRUCTIONS FOR FILLING OUT THE MEMBER AUTHORIZATION FORM

Use the member authorization form to authorize Blue Cross of Idaho to share a member's personal health information with an individual or organization not otherwise authorized to receive the information. Only the member or the member's personal representative can authorize the release of a member's personal health information (see description of personal representative below).

1. **Member Information**: Complete all information in this section for the member whose information is to be disclosed. Note: Name, date of birth, policy ID, and address are all required fields. If you do not have the policy ID number, please provide the member's social security number.

2. **Authorization and Purpose:** You must identify the individual(s) or organization you wish to share the member's personal health information with. Blue Cross of Idaho will only disclose personal health information to the named individual(s) or organization.

3. **Description of Information to Be Disclosed:** You may choose to authorize Blue Cross of Idaho to share "All" of the member's personal health information or "Specific" information with the designated individual(s) or organization. If you choose "Specific" information, please identify the types of information to be disclosed (for example: benefit information, enrollment/billing information, claims information, etc.).

4. **Expiration:** Check one of the two boxes provided to show when you want this authorization to expire. If you check the "Specific Date" box, you must write in a specific date (mm/dd/yyyy). If you do not indicate a specific expiration date, this form will expire two years from the date of signature. To revoke this authorization form, send a written request to the Information Privacy Officer at the address below.

5. **Signature:** You must sign and date your own authorization form unless you are the legal personal representative* (see below) or the parent of a minor child. If the member is 18 years old or older, the member must sign and date his or her authorization form.

*** Personal Representative:** A personal representative is a member's legal guardian, someone who has power of attorney over the member's medical insurance decisions or a parent (if the member is a dependent child under the age of 18 and not an emancipated minor). Also, a personal representative can be an executor, administrator, or person legally authorized to act on behalf of a deceased member or the member's estate. Other than a parent acting on behalf of a dependent child under the age of 18 who is not an emancipated minor, ***Blue Cross of Idaho requires a copy of the power of attorney or other court-initiated document as proof that we should recognize the individual named as the member's personal representative.*** For this form to be processed, it is important that a copy of any applicable power of attorney or other court-initiated document be included when you return this form to Blue Cross of Idaho.

Unless directed otherwise, please return this completed and signed form to:

Customer Service
Blue Cross of Idaho
PO Box 7408, Boise, ID 83707 • Fax to: 208-331-7493

bcidaho.com

Form No. 3-1195NI (11-17)

MEMBER AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Please see Instructions for Filling out Member Authorization

1. Member Information (member whose information may be disclosed)

Name: _____ Date of Birth: _____

Blue Cross of Idaho ID#:_____ Program/Group#: _____

Street Address: _____

City/State/ZIP: _____ Phone: _____

2. Authorization and Purpose

At my request, I authorize Blue Cross of Idaho to disclose the above member's personal health information (as described below) to:

Person(s) or Organization Receiving the Information: _____

Street Address: _____

City/State/ZIP: _____Phone: _____

3. Description of personal health information to be disclosed

All ❑ Specific (describe): _____

4. Expiration

This Authorization expires on: Specific Date: _____ or ❑ When my coverage expires

Note: If you do not indicate a specific date, this authorization will expire two years from the signature date.

5. Signature

I understand: If the person or organization that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the person or organization may not be obligated by state or federal law to protect it. I may cancel this authorization in writing at anytime by sending a written request to Blue Cross of Idaho. My cancellation of this authorization will not affect any action Blue Cross of Idaho took before it received my request. This authorization is voluntary. Blue Cross of Idaho will not condition my enrollment in the health plan or eligibility for benefits on receiving this authorization.

Your Signature _____ Today's Date _____

If signed by a personal representative of the member, please complete the following and attach documentation of your legal authority to act on behalf of this member.

Name of Personal Representative (please print) _____Phone _____

Relationship to Member: _____

Please mail, email or fax your completed form to:

Customer Service • Blue Cross of Idaho

PO Box 7408, Boise, ID 83707 • Fax: 208-331-7493 • Email: customerservice@bcidaho.com

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

ATTENTION: If you speak Arabic, Chinese, French, German, Korean, Japanese, Persian (Farsi), Romanian, Russian, Serbo-Croatian, Spanish, Sudanic Fulfulde, Tagalog, Ukrainian, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 1-800-377-1363).

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY：1-800-377-1363)。

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 1-800-377-1363).