# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

**Date:** _____

**From:** (Name of patient/subject of the medical information**):**_____

**Subscriber ID number** (covered employee):

_____

**Address of member/patient:** _____

_____

**To:** _____

(HMO or Insurance Company)

**In accordance with California Civil Code 56.11, California Insurance Code 791.06, 45 CFR 164.508, and/or other applicable law, I hereby authorize the release of any and all medical information or records relating to:**

☐ Claims/Billing _____ ☐ Services Rendered

☐ Other - Specify_____ ☐ Medical Treatment

Explain Specific Issue : _____

_____

_____

_____

_____

Subject to the following limitations:_____

_____

## Release information to:

**Name:_____ Company:_____**

(Name of Broker representative and name of Brokerage firm or Name of Human Resources Representative and name of Company Account (client) he/she represents or other organization – the "Recipient") for the purpose of:

☐ Inquiry and review ☐ Administration of Coverage

☐ Investigation * ☐ Evaluation of any Claims/Benefits

☐ Financial Audit * ☐ Other _____

***** Depending on the nature of the inquiry these issues may have to be handled and tracked by the Grievance and Appeals Department.

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION - CONTINUED

**This authorization is effective immediately and shall remain in effect for a period of 90 days from the date above.**

I understand that I may revoke this authorization at any time. My revoking this authorization doesn't apply to any information already disclosed before I've effectively revoked this authorization. If I want to revoke this authorization, I have to do it in writing and send the notice to Blue Cross of California, addressed to the P.O. Box listed on the back of .my ID card. I understand that any information disclosed under this authorization to the Recipient **might not be protected by state or federal confidentiality rules and could be disclosed by the Recipient.**

A copy of this authorization is as valid as the original, and I am entitled to receive a copy of this form.

_____ Date: _____

Signature of Patient/Legal Guardian/Parent
Parent/ Personal Representative*

_____

Relationship to Patient (*A Personal Representative must describe his/her authority to act for the patient and the reason he/she has that authority.)

If a patient is 18 years or older he/she must sign this form. If the patient is under 18 the parents or guardian must sign.

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## Blue Cross Internal Instructions:

### Sales:

Verify that form is completed and signed.
Please keep a copy of this form in your client file and fax form to Grievance Representative in the appropriate MBU for imaging.

### Operations:

Verify that form is completed and signed. Image form – load CSR limited liability record with MLG number. Make certain we have actually disclosed only the types of information covered by the authorization and assure that we have not exceeded the scope of the authorization. Send copy of form to member at above address with a cover letter.

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