



**4 I authorize the following disclosure of my protected health information to the person/organization listed above.**

Check all that apply.

- ALL of my information
- Enrollment and Benefits information
- Any documents related to an appeal
- Claims and Explanation of Benefits (EOB) information
- Premium payment information
- Mental health and substance abuse information

**To further limit the information being shared, please be as specific as possible when selecting the options below.**

- All services for a specific date (provide dates of service): From: \_\_\_\_\_ To: \_\_\_\_\_
- All services from a specific health care provider (list provider's name): \_\_\_\_\_  
\_\_\_\_\_
- Other (please list specific PHI): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5 Expiration**

I would like this authorization to expire:

- on   /   /     (Check this option if you want the authorization to expire in **less** than one year.)
- after a specific event has occurred (e.g. after heart surgery or at the end of the pregnancy):  
\_\_\_\_\_  
\_\_\_\_\_

***This authorization will expire one year from the date signed unless you select one of the options above.***

**6 Right to Revoke (cancel)**

I understand that I may revoke this authorization at any time by giving written notice to my health plan or health plan administrator. I can write a letter or download a special form from the web site at **www.carefirst.com**. Revoking this authorization will not affect any action that my health plan or health plan administrator, or others named or unnamed herein, took before my health plan or health plan administrator received my written notice of revocation.

The Notice of Privacy Practices includes information about the opportunity to revoke an authorization, and the exceptions to this right. You may refer to the Notice of Privacy Practices for this and all other information pertaining to your Privacy rights.

**7**

I, \_\_\_\_\_, hereby authorize the use and/or disclosure of my identifiable health information as described above.

I understand that:

- 1. this authorization is voluntary and being made at the request of the individual;
- 2. the released information may no longer be protected by federal privacy laws and may be redisclosed by the individual or organization authorized to receive the information; and
- 3. this authorization will not be used for medical underwriting; therefore, my treatment, payment, enrollment or eligibility for benefits will not be conditioned on my signing this authorization.

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to my health plan or health plan administrator. I understand that by signing this form, I am giving my authorization to my health plan or health plan administrator to use and/or disclose the protected health information described above to the persons and/or organizations named in this form.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If the person signing this authorization is not the member\*, please provide your full name and describe the relationship to the member.

\_\_\_\_\_  
**Print Your Full Name**

- Personal Representative                       Power of Attorney                       Legal Guardian
- Other \_\_\_\_\_

***\*The proper documentation must be on file before the authorization can be processed.***

**8 Please mail or fax this authorization to:**

**CareFirst BlueCross BlueShield Privacy Office  
c/o CareFirst BlueCross BlueShield  
10455 Mill Run Circle, TBP-06  
Owings Mills, MD 21117  
Fax: 410-561-7988**

**Please keep a copy of this authorization.  
We will provide you with a signed copy of this authorization upon request.**

Any mental health or substance abuse information, which has been disclosed from medical or other health care records, may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.