

Authorization for Disclosure of Protected Health Information

This Authorization is Voluntary

Person Granting Authorization	Policy Holder Information
Date: _____	ID Number: _____
Name: _____	Name: _____
Address: _____	Address: _____
Date of Birth: _____	Telephone: _____

I authorize and direct Blue Cross Blue Shield FEP VisionSM and its affiliates to furnish and release vision care insurance information regarding the person noted above.

Information to Be Disclosed:

_____ Participating Vision Care Providers

_____ Benefit, Policy and Procedure information

_____ Vision Care Claims Information

_____ Vision Care Claims Review Information

_____ Eligibility Information

_____ Other _____

Purpose of Disclosure:

_____ To provide information to a family member or friend

_____ As required for a legal matter

_____ Other _____

Person(s) or Organization(s) To Receive the Identified Information:

Name: _____

Street Address: _____

City, State, Zip: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Name: _____

Street Address: _____

City, State, Zip: _____

My protected health information is information about me, including information such as my name and address and/or medical information. The information was used or created when I received vision care or when payment was received for my vision care. The information may include my past, present or future vision health care or condition.

I understand that if the persons or organizations I authorize to receive and/or use the protected health information described above are not 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 my authorizing the use and disclosure of my "protected health information" is not a condition of my enrollment in the BCBS FEP VisionSM plan, my eligibility for benefits or payment of my claims.

Expiration: This authorization will expire on ____ / ____ / ____ or on occurrence of the following event _____

Right to Revoke: This authorization may be revoked at any time. BCBS FEP VisionSM Privacy Contact Office at 1-800-571-3366 for further instructions. Revocation of this authorization will not affect any action taken before BCBS FEP VisionSM receives the notice of revocation.

Signature: _____ **Date:** _____
(Person Granting Authorization)

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____
(Please Print)

Description of Personal Representative Authority: _____

PLEASE RETAIN A COPY OF THIS SIGNED AUTHORIZATION FOR YOUR RECORDS

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FORM

Please read the instructions below before completing the Authorization form. The information you provide will be used to fulfill your request to disclose your protected health information and identify the person(s) who will be receiving your information. All required sections of the form must be completed in order for us to process this request. If required information is not completed, we will not disclose your protected health information. In certain circumstances, a written authorization to disclose your protected health information to a third party specified by the individual is required by law.

Section 1 - Member Information (Required)

This section must be completed with the information specific to the individual. A contact number or address is needed in case additional information or clarification is required.

Section 2 - Granting Authorization/Specification of Information to be Disclosed (Required)

Select the type of Protected Health Information to be disclosed. If OTHER, specify what information you wish disclosed.

Section 3 - Purpose of Disclosure (Required)

Select the purpose of this authorization to disclose Protected Health Information. If OTHER, specify the reason for the authorization.

Section 4 - Designate the Recipient(s) (Required)

Identify to whom the requested information is to be provided.

Section 5 - Important Information (Required)

Please read this section carefully.

Section 6 - Expiration/Revocation of an Authorization (Required)

You must indicate a date or event that will trigger the expiration of this authorization. Once an authorization has expired, the person who has been receiving your information will no longer be able to receive your information. If an event will trigger the expiration of this authorization, please indicate that event in the space provided.

Section 7- Signatures and Personal Representatives (Required)

The individual whose information is being disclosed must sign and date in the space provided. If this form is completed by your personal representative, he or she must include his or her name and relationship to you. (e.g. attorney-in-fact, guardian, executor, parent of a minor, etc.)

Please Return the Completed Authorization Form to the Address Below:

BCBS FEP VisionSM - Privacy Office
PO Box 1416
Latham, NY 12110-1416
Telephone: 1-800-571-3366
Fax: 1-866-999-4640