



**Instructions for Completing  
Standard Authorization Form**  
**To Complete Form go to Page 4 of 5**

Use this form to authorize Blue Cross Blue Shield of Texas to disclose your protected health information (PHI) to a specific person or entity. You may follow the instructions we provided below or you may call the Customer Service number listed on the back of your Membership Identification card for assistance in completing the form. You must complete all the fields on this form.

Please remember:

- One **authorization form** can be used for a range of and/or multiple services or providers.
- **Authorization** forms can be completed claim by claim, procedure by procedure, or for services within specified timeframes.
- The **individual's** use of the **authorization form** is always voluntary.

**I. Individual** (Name and information of person whose protected health information is being disclosed):

<b>Jane Doe</b>		<b>05-10-1962</b>	
Name		Date of Birth	
<b>123456</b>	<b>XOP123456789</b>	<b>###-##-####</b>	
Group #	Identification/Subscriber #	Social Security Number	
<b>123 Main Street</b>	<b>Anytown</b>	<b>TX</b>	<b>12345</b>
Address	City	State	ZIP
<b>312-555-1212</b>			
Area Code & Telephone Number			

All of the information in **Section I** pertains to the individual for whom the authorization is being requested. The individual may be the subscriber, his or her spouse, a dependent or any other **individual** covered or applying for coverage under the subscriber's membership. All fields in this section are **required**. In this example, Jane Doe is the individual for whom the authorization is being requested.

**II. Authorization and Purpose:**

I request and authorize Blue Cross and Blue Shield of Texas to disclose my protected health information as described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

<b>Suzy Smith</b>	<b>Daughter</b>	<b>Assisting in medical care</b>	
Persons/Organizations authorized to receive your information	Relationship	Purpose	
<b>456 Mill Road</b>	<b>Happytown</b>	<b>TX</b>	<b>45678</b>
Address	City	State	ZIP

**Section II** identifies the person/entity that will be receiving the PHI about the individual identified in Section I. An individual could authorize disclosure of his or her PHI to a close friend, a broker, an attorney, or a specific member of his or her employer's benefits staff. The individual may also authorize disclosure to an organization. Include the information identifying the organization's job titles to receive the PHI (e.g., Benefits Representatives, Human Resources Department, XYZ Insurance Agency, etc.). In this example, Jane Doe has identified her daughter, Suzy Smith as the person who is authorized to receive her information.

**III. Specific Description of Information to be Used or Disclosed** *(Please Complete Parts A and B in this Section)*

**This Authorization CANNOT be used to disclose Psychotherapy Notes.**

Section III will assist in determining what PHI the individual identified in Section I allows the receiving person/entity identified in Section II to receive. This section has two parts, both of which must be completed.

**A. Release of Sensitive Protected Health Information Under State Law**

You must check “yes” or “no” if you authorize the release of medical information, test results, records or communications specific to *(note: “yes” means this information is included in the categories you designate in Part B below):*

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome Yes
- Sexually transmitted or “communicable” diseases (includes hepatitis, as well as venereal diseases); No
- Drug, alcohol or substance abuse;
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions); and
- Genetic testing.

**Section III A.** asks if the authorizing individual identified in Section I wants the receiving person/entity identified in Section II to receive **Sensitive** Protected Health Information (SPHI). SPHI are certain types of health information for which various states’ laws require extra protections. Either “Yes” or “No” must be chosen. In this example, Jane has agreed to let Suzy receive her SPHI.

**B. Release of Protected Health Information** *(check one or more)*

**Dates of Services**

**From: To:**

<input type="checkbox"/> Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).	_____	_____
<input checked="" type="checkbox"/> Claims Information:	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.).	6-12-05	4-30-08
<input type="checkbox"/> Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.	_____	_____
<input type="checkbox"/> Premium	Includes information related to billing cycles, bank draft changes, etc.	_____	_____
<input type="checkbox"/> Services from (provider or supplier):	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier.)	_____	_____
<input type="checkbox"/> Other:	_____		

(Specify other information that is not listed in one of the categories above.)

**Section III B.** asks for the specific types of information that the individual identified in Section I is authorizing BCBSTX to disclose to the person/entity identified in Section II. In this example, Jane is authorizing BCBSTX to provide her daughter with her claims information for the time period listed. “Dates of Service” means disclosing information for health care services the individual received during a particular time period. For example, in this case Jane Doe is authorizing BCBSTX to disclose claims information for health care services provided during June 12, 2005 through April 30, 2008.





I. Individual (Name and information of person whose protected health information is being disclosed):

Name, Date of Birth, Group #, Identification/Subscriber #, Social Security Number, Address, City, State, ZIP, Area Code & Telephone Number

II. Authorization and Purpose:

I request and authorize Blue Cross and Blue Shield of Texas to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive your information, Relationship, Purpose, Address, City, State, ZIP

III. Specific Description of Information to be Used or Disclosed (Please Complete Parts A and B in this Section)

This Authorization CANNOT be used to disclose Psychotherapy Notes.

A. Release of Sensitive Protected Health Information Under State Law

You must check "yes" or "no" if you authorize the release of medical information, test results, records or communications specific to (note: "yes" means this information is included in the categories you designate in Part B below):

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome
Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases);
Drug, alcohol or substance abuse;
Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions); and
Genetic testing.

Yes [ ]
No [ ]

Dates of Services

B. Release of Protected Health Information (check one or more)

Health Plan Benefit Information, Claims, Service Determination Information, Premium, Services from (provider or supplier); Includes information contained in your benefit booklet, Includes information related to payment of your claims, Includes any information related to pre-service, concurrent and post-service decisions, Includes information related to billing cycles, bank draft changes, etc., Provider name: (Includes information related to services rendered by a specific provider or supplier.)

Other:

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(Specify other information that is not listed in one of the categories above.)

**IV. Expiration and Revocation:**

**Expiration:** This authorization will expire on (must choose one):

- One year from the date it is signed
- Other (insert date or event): \_\_\_\_\_

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

**V. Signature** (this document must be signed by the individual, parent of minor child or the individual's personal representative):

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

\_\_\_\_\_  
**Signature** \_\_\_\_\_  
**Date: month/day/year**

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of these documents if they are already on file with Blue Cross and Blue Shield of Texas:

<b>Personal Representative's Name</b>	<b>Relationship to Individual</b>
<b>Personal Representative's Address</b>	<b>City</b>
<b>Personal Representative's Area Code &amp; Telephone Number</b>	<b>State</b> <b>ZIP</b>

- BEFORE RETURNING THIS FORM YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:**
- (3) MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR**
  - (4) COMPLETING THE DUPLICATE AUTHORIZATION FORM, YOU RECEIVED OR PRINTED**

**Mail your completed signed authorization to:**  
**Blue Cross and Blue Shield of Texas**  
**P.O. Box 660044**  
**Dallas, TX 75266-0044**

**If you need assistance completing the form, please refer to the instructions above or contact the Customer Service number listed on the back of your Member Identification Card.**

**Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the HCSC Privacy Office. Please contact the Privacy Office with any change requests.**



If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فليك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضواً، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રાહ છો તો અથવા તમે કોઈ બીજાને મદદ કરવા માટે, તમારા સહયોગી કાર્ડના પાછળ આપેલ ગ્રાહક સેવા નંબર પર કોલ કરો. જો આપ સહયોગી ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे ह उसके, प्रश्न ह, तो आपको अपनी भाषा में नि:शुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
日本語 Japanese	ご本人様、またはお客様の方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오. 회원이 아니거나 카드가 없으면 855-710-6984 으로 전화하십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີ ກຳລັງ, ທ່ານມີ ີດຂໍອໍາການຊ່ວຍເຫຼືອ ຕະຫຼອດ ຂໍບໍ່ມີຄ່າໃຊ້ຈ່າຍ ທີ່ ອົງການບັນດາພາສາ, ໃຫ້ໃຫ້ທ່ານບໍລິການຊ່ວຍເຫຼືອທີ່ ບໍ່ມີ ັດຂໍບໍລິການຊ່ວຍເຫຼືອ ທ່ານ. ຖ້າທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ, ຫຼື ບໍ່ມີ ັດ, ໃຫ້ ໃຫ້ທ່ານ ການ ຈຳນວນ 855-710-6984.
Diné Navajo	T'11 ni, 47 doodago [a'da b7k1 an1n7lwo'7g77, na'7d7[kidgo, ts'7d1 bee n1 ah00ti'i' t'11 n77k'e n7k1 a'doolwo]. Ata' halne'7 bich'8' hadeesdzih n7n7zingo 47 kwe'4 da'7n7ishgi 1k1 an7daalwo'7g77 bich'8' hod77lnih, bee n44h0zinii bine'd66' bik11'. Koj7 atah naaltsoos n1 had7t'44g00 47 doodago bee n44h0zin7g77 1dingo koj8' hod77lnih 855-710-6984.
فارسی Persian	تما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulongan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.



**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St.  
35th Floor  
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960  
Email: [CivilRightsCoordinator@hcsc.net](mailto:CivilRightsCoordinator@hcsc.net)

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>

BCBSTX provides TDD/TYY services and language assistance for incoming callers for deaf, hard-of-hearing and speech-disabled members. Members can utilize their TeleTYpewriter (TTY) or Telecommunication Device (TDD) to access a teletype operator at 1-800-735-2989.