blue california®

Promise Health Plan

Authorization for the release of health information

Use this form to authorize Blue Shield of California, Blue Shield of California Life & Health Insurance Company, and their business associates (collectively "Blue Shield") to release your health information to another person or organization.

1. Member information

Member name:

Member address:

Subscriber ID number:

Date of birth:

2. Who may receive information?

Recipient name:

Recipient address:

Recipient's relationship to the member:

3. What is the purpose of completing this form? (Check one)

☐ New authorization (Proceed to number 4)

☐ Revoke an existing authorization (Skip to number 7)

4. What is the purpose of the disclosure of information? (Check one)

☐ At my request - No specific purpose

☐ Specific purpose: _____

5. What information may be shared with the recipient? (Check all that apply)

☐ Explanation of benefits

☐ Claims information

☐ Premium billing information

☐ Case management

☐ Any or all information Blue Shield Promise Health Plan maintains. This may include information relating to your medical care, diagnosis, providers, insurance or benefit claims/payments, and/or financial/billing information. This does not include sensitive information unless specifically approved below.

☐ Other (Specify, including specific date range if applicable): _____

6. Is the recipient authorized to receive sensitive information? (Check one)

☐ No

☐ Yes (Check all that apply)

- ☐ Contagious and infectious disease
- ☐ Gender affirming care
- ☐ Genetic information
- ☐ HIV/AIDS
- ☐ Mental or behavioral health
- ☐ Sexual and reproductive health - Other
- ☐ Sexual and reproductive health - Abortion
- ☐ Sexual and reproductive health - Abortion - related services
- ☐ Sexual and reproductive health - Contraception
- ☐ Sexual, physical, or mental abuse, including intimate partner violence
- ☐ Sexually transmitted infections
- ☐ Substance use disorder (Alcohol/drugs)

7. Expiration and revocation

I would like this authorization to end on _____. (ex: ___/___/___)
If no date is selected, the authorization will expire one year from the date of signature below. You have the right to revoke this authorization at any time by notifying Blue Shield Promise Health Plan in writing. Revoking this authorization will not affect information we disclose before we receive your revocation request. If this authorization is given by a parent or legal guardian on behalf of a minor, it will expire on the minor's eighteenth birthday.

8. Signature of member or legal representative

I have read this form and I understand and agree to its terms. I direct Blue Shield Promise Health Plan to disclose the information to the noted recipient as directed above. I understand that once my information is disclosed, it could be re-disclosed by the recipient and may no longer be protected by privacy laws, including the federal Health Insurance Portability and Accountability Act of 1996. I understand that Blue Shield Promise Health Plan may not condition payment, enrollment in a health plan, or eligibility for benefits on whether I sign this authorization.

_____ _____

Signature Date

_____

Print name

If a legal representative signed this form, please provide representative's name and relationship to member (parent, court-ordered guardianship, Power of Attorney for Health Care, etc.):

_____

If this form is signed by someone other than the member or the parent of a minor, such as a personal/legal representative, guardian, or executor, **you must also submit legal documentation** showing your authority to act on behalf of the member (Or the member's estate) to release health information. Such documentation may include, for example:

1. Power of Attorney for Health Care
2. Current, valid documentation of court-ordered guardianship; or
3. Other valid legal documentation showing your authority to act on behalf of the member (Or the member's estate)

Keep a copy of the authorization form for your records.
Return the completed and signed authorization form to:

Blue Shield of California Promise Health Plan Customer Service
P.O. Box 272540
Chico, CA 95927-2540