HIPPA Authorization

In accordance with the HIPAA Privacy Laws, we cannot release your health information without your written consent. If you want your information disclosed to another party, please complete, and sign this Authorization form.

HIPPA AUTHORIZATION FORM

A. Member Name________________________ ID# ___________________________________

Requests authorization to release information be granted to:

B. _____________________________________ _____________________________________
Name Address

C. This authorization applies to: (check one)

- ❑ One service only. Date of service_____________________ Doctor/Supplier _________________________
- ❑ All services (all dates and all providers)
- ❑ All services from (doctor or supplier): ____
- ❑ Medicare eligibility information
- ❑ Information on other health coverage: ____
- ❑ Deductible information for (year): ____
- ❑ Copy of Explanation of Benefits for:

Date of Service Doctor / Supplier
_______________________________ ____________________________________

D. State how long you wish this authorization to be in effect:

❑ One time release
❑ Ongoing release until otherwise revoked, or until the specified time period of this authorization exists. A revocation will not apply to information already released.

If you have questions or need any additional assistance, including free language translation services, our customer service team is available seven days a week from 8 a.m. to 8 p.m. at 1-866-508-7140. TTY users may call 711 toll free. You may reach a messaging service on weekends and holidays from April 1 through September 30. Please leave a message, and your call will be returned the next business day.

E. **Member Signature**

This Authorization is voluntary and refusal to sign this Authorization will have no effect on your enrollment, eligibility for benefits, or the amount Blue Medicare Advantage pays for the health services you receive. You may revoke this Authorization by sending a written revocation to the address at the end of this form. The information disclosed by Blue Medicare Advantage under this Authorization may be re-disclosed by the recipient and no longer protected by federal or state law.

_________________________________ _____________________________________
Signature of Member **Date**

(If this form is signed by someone other than Member, see Section F).

F**. Legal Representative**

If this authorization is signed by a legal representative or someone other than the Member identified in Section A above, complete the following:

By signing the form, U represent that I am the legal representative of the Member identified in Section A and will provide Blue Medicare Advantage with written proof (e.g. Power of Attorney, living will, guardship papers, etc.) that I am legally authorized to act on the Member's behalf with the respect to this authorization form.

Name of Legal Representative: ____

Signature: ____

Date: ____

Relationship to Member: ____

Return this form to: <**Blue Medicare Advantage**
P.O. Box 7065
Troy, MI 48007>

Blue Cross and Blue Shield of Kansas City is an independent licensee of the Blue Cross and Blue Shield Association. The HMO products are offered by Blue-Advantage Plus of Kansas City, Inc. and the PPO products are offered by Missouri Valley Life and Health Insurance Company, both wholly-owned subsidiaries of Blue Cross and Blue Shield of Kansas City. Blue Cross and Blue Shield of Kansas City's Blue Medicare Advantage includes both HMO and PPO plans with Medicare contracts. Enrollment in Blue Medicare Advantage depends on contract renewal.

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