Designation of Representative /Authorization Form

This form is to be filled out by a member if there is a request to release the member's health information to another person or company or a request to appoint an Authorized Representative. Please include as much information as you can.

PART A: MEMBER INFORMATION

Member last name	Member first name	Middle Initial	Member date of birth
Member street address	**City**	**State**	**ZIP code**

Daytime phone number (with area code)	Identification number (see identification card)	Group number (see identification card)

PART B: PERSON OR COMPANY WHO CAN RECEIVE MY INFORMATION

The following people or companies have the right to receive my information. They must be 18 years of age or older.

Please check each box that applies and enter first and last name.

☐ **My spouse** (enter first and last name)	☐ **My parents** (if you are over 18 – enter first and last name[s])
☐ **My domestic partner** (enter first and last name)	☐ **My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
☐ **My adult children** (enter first and last name[s])	☐ **Other** (enter first and last name [if you have it], name of company, and how it's related to you)

PART C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be used or released by Empire Blue Cross and Blue Shield on my behalf (check only one box):

☐ **All my information.** This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ **Only limited information** may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Doctor and hospital
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other: _____

I also approve the release of the following types of sensitive information by Empire Blue Cross and Blue Shield (check all boxes that apply to you):

☐ **All sensitive information; OR**

☐ **Just information about topics checked**

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance abuse **
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

PART D: PERSON OR COMPANY WHO CAN ACT AS MY AUTHORIZED REPRESENTATIVE

The following person or company has the right to act as my Authorized Representative. An Authorized Representative is a person who you appoint to be your representative in carrying out a grievance or appeal, including any external review rights that may be available to you. They must be 18 years of age or older. Please also complete Part B and C above to authorize the release of your information to your Authorized Representative.

Please check each box that applies and enter first and last name.

☐ My spouse (enter first and last name)	☐ My parents (if you are over 18 – enter first and last name[s])
☐ My domestic partner (enter first and last name)	☐ My insurance broker or agent (enter the name of the company and first and last name, if you have it)
☐ My adult children (enter first and last name[s])	☐ Other (enter first and last name [if you have it], name of company, and how it's related to you)

PART E: DATE YOUR APPROVAL EXPIRES

If this document was not already withdrawn, this approval will end:

☐ At the conclusion of the appeals process.
☐ One year from the signature date in Part G.
☐ Upon the date, event or condition described below (please provide details):

PART F: PURPOSE OF THIS APPROVAL

☐ To allow an individual to act as my Authorized Representative in carrying out a grievance or appeal, including any external review rights that may be available to me.
☐ To disclose information at my request.

PART G: REVIEW AND APPROVAL

I have read the contents of this form. I understand, agree, and allow Empire Blue Cross and Blue Shield to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Empire Blue Cross and Blue Shield does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Empire Blue Cross and Blue Shield. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature	Date
X	

DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney; OR
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)		Legal relationship to member	
Legal representative street address	City	State	ZIP code
Signature X		Date	

Please return the completed form to:
Empire Blue Cross and Blue Shield
PO Box 1407
Church Street Station
New York NY 10008-1407

Be sure to keep a copy of this form for your records.

FOR RECIPIENT OF SUBSTANCE ABUSE INFORMATION

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further 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.