

# Authorization Form

**The Member's Information:** Insert information about the individual whose information will be released.

Member Name: \_\_\_\_\_  
Member Address: \_\_\_\_\_  
Member Phone Number: \_\_\_\_\_ Member Date of Birth \_\_\_\_\_  
Member ID No (on card) \_\_\_\_\_ Member Social Security No. (Optional) \_\_\_\_\_

**Who Can Release and Receive the Information:** Insert the person/company/doctor's office who is allowed to release the information and the person/company who is allowed to receive the information.

The following person/company is allowed to release the information as requested: \_\_\_\_\_

The information can be provided to (include address): \_\_\_\_\_

**What Information is Being Released:** Insert what information you are authorizing to be released. Describe in detail the kind of information (e.g. claims information, premium information, medical records, etc.) you want released and if applicable, the date(s) of the information (e.g. claims for the last 6 months, premium payment record for January, etc.).

In addition, if you agree that the following types of information may be released, please indicate so by checking the appropriate boxes:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Psychotherapy Notes*                                | <input type="checkbox"/> Mental Health Records           | <input type="checkbox"/> Genetic Testing Records      |
| <input type="checkbox"/> HIV or AIDS Records                                 | <input type="checkbox"/> Alcohol/Substance Abuse Records | <input type="checkbox"/> Maternity Records            |
| <input type="checkbox"/> Sexually Transmitted or other Communicable Diseases | <input type="checkbox"/> Abortion                        | <input type="checkbox"/> Sexual/Physical/Mental Abuse |

*\*If this authorization is for psychotherapy notes, this authorization cannot be used for any other type of protected health information. If you want to authorize the use or disclosure of other protected health information as well, an additional form must be submitted.*

**Purpose of the Release of Information**

- At the request of the member, or  
 If not requested by the member, state the purpose of the release of the information: \_\_\_\_\_

**Expiration Date: If not previously revoked, this authorization will expire one year from the signature date below.**

- 1) The date the individual's coverage ends; or 2) One year from the signature date below; or  
3) Upon the following date, event or condition: \_\_\_\_\_

(If an event or condition is specified, the company must be notified in writing of the event or condition for revocation to be effective.)

*A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. I understand that IF this information is to be received by individuals or organizations that are not healthcare providers, healthcare clearinghouses, or health plans covered by the federal privacy regulations, my information described above may be re-disclosed by the recipient and no longer protected by the federal privacy regulations. This authorization is subject to revocation at any time upon written notice to the person/company specified below except to the extent that the person/company has already taken action on the disclosure provision contained in this document.*

*Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to BlueCross BlueShield of Tennessee, Privacy - 1 Cameron Hill Circle, Building 1, 5th Floor, Chattanooga, Tennessee 37402. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.*

**X**

Signature of Adult Member, Parent on Behalf of Minor, as applicable

\_\_\_\_\_ Date

**X**

Signature of Legal Representative, if applicable

\_\_\_\_\_ Date

*If a legal representative signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form (e.g. guardianship, conservatorship, custody, etc.).*

**NOTE: You are entitled to a copy of this authorization**

**¿Habla español y necesita ayuda con esta carta?** Llámenos gratis al BlueCare **1-800-468-9698**. Llámenos gratis al TennCareSelect **1-800-263-5479**.

**We do not allow unfair treatment in TennCare<sup>SM</sup>.** No one is treated in a different way because of race, color, birthplace, religion, language, sex, age, or disability. Do you think you've been treated unfairly? Do you have more questions or need more help? If you think you've been treated unfairly, call the Tennessee Health Connection for free at **1-855-259-0701**.

If you have a hearing or speech problem you can call us on a TTY/TDD machine. Our TTY number is **711** and ask for **888-418-0008**.

**Need help in another language?** You can call TennCareSelect for assistance in any language at **1-800-263-5479** or the numbers below. Call BlueCare for language assistance at **1-800-468-9698** or the numbers below. Interpretation and translation services are free to TennCare members.

**Foreign Language Lines** call if you need help and need to speak with someone in one of these languages:

العربية (Arabic)	1-800-758-1638
Bosanski (Bosnian)	1-800-758-1638
كوردی - بادینانی (Kurdish-Badinani)	1-800-758-1638
كوردی - سورانی (Kurdish- Sorani)	1-800-758-1638
Soomaali (Somali)	1-800-758-1638
Español (Spanish)	1-800-758-1638
Ngúoi Việt (Vietnamese)	1-800-758-1638

**Do you need help with this information?** Is it because you have a health, mental health, or learning problem or a disability? Or, do you need help in another language? If so, you have a right to get help, and we can help you. Call BlueCare Customer Service at **1-800-468-9698** for more information. Call TennCareSelect Customer Service at **1-800-263-5479** for more information. Do you have a mental illness and need help with this information? The TennCare Advocacy Program can help you. Call them for free at **1-800-758-1638**



BlueCare Tennessee  
1 Cameron Hill Circle | Chattanooga, TN 37402  
bluecare.bcbst.com

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