Excellus

A nonprofit independent licensee of the BlueCross BlueShield Association

Important Facts Regarding Your Authorization to Share Protected Health Information

- In order to comply with Federal HIPAA regulations health plans must obtain a member's permission to share his/her protected health information with any other person. There are limited exceptions to this.

- As permitted by law, we will continue to communicate to providers of care involved in your treatment: (1) our payment activities in connection with your claims, (2) your enrollment in our health plan and (3) your eligibility for benefits.

- Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents do not have access to diagnosis or treatment information for sexually transmitted diseases, abortion, and drug or alcohol abuse unless the child specifically authorizes the release of such information.

- This form is used to authorize us to share your protected health information. Each person you identify will have the same access to your information. If you would like each person to access *different* information or to have access to your information for a *different* period of time, you'll need to complete separate forms for each individual or time period.

- We will NOT disclose information relating to genetic testing, alcohol and drug abuse, mental health, abortion, and sexually transmitted disease information unless you check the corresponding box in Part D. If you would like to authorize us to release information regarding HIV/AIDS, New York State requires that a different form be completed. To obtain a copy of this form, please contact our office at the telephone number listed on your identification card, or access the form at the following website: http://www.health.state.ny.us/diseases/aids/forms/informedconsent.htm.

- If you need additional forms, you may copy this form, contact our office at the telephone number listed on your identification card or visit our Web site at https://www.excellusbcbs.com and search for "Manage Your Privacy".

INCOMPLETE FORMS WILL NOT BE PROCESSED -
BE SURE TO RETAIN A COPY FOR YOUR RECORDS

AUTHORIZATION TO EXCELLUS HEALTH PLAN, INC. ("HEALTH PLAN") TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

☐ Check here only if you are authorizing access to psychotherapy notes.
If checked, this form cannot be used for any other purpose. You must complete a separate form for authorizing access to any other information. If this box is checked, skip Part D.

PLEASE PRINT

PART A: MEMBER/INDIVIDUAL WHO IS THE SUBJECT OF THE INFORMATION TO BE DISCLOSED

LAST NAME	FIRST NAME	MI	DATE OF BIRTH *MM/DD/YYYY*	IDENTIFICATION # - located on ID card(s)

CURRENT ADDRESS	CITY	STATE/ZIP CODE

PART B: HEALTH PLAN CAN SHARE MY INFORMATION WITH THE FOLLOWING PERSON(S)

NAME OF PERSON/ORGANIZATION	ADDRESS
NAME OF PERSON/ORGANIZATION	ADDRESS

PART C: REASON FOR MEMBER/INDIVIDUAL (PART A) AUTHORIZING DISCLOSURE

☐ Assist with health insurance matters ☐ Other: _____

PART D: HEALTH PLAN CAN SHARE THE FOLLOWING INFORMATION (check all that apply)
NOTE: ***Skip this section if psychotherapy was checked at the top of this form***

☐ Any information requested *(including anything checked in the specified conditions below)*

If you would like to limit the disclosure of information to a specific provider, condition or date(s), or to any of the following documentation type, please specify:

☐ Enrollment *(e.g. eligibility, address, dependents, birth date)*
☐ Benefit *(e.g. benefit coverage, usage, limits)*
☐ Claim *(e.g. status, provider, dates, payment, diagnosis)*
☐ Clinical records *(e.g. doctor/facility, case management)*
☐ Other limitation: _____
☐ Date Range *MM/DD/YYYY* to *MM/DD/YYYY*

I choose to include information regarding the following conditions *(check all that apply):*

☐ Genetic testing ☐ Sexually transmitted diseases ☐ Abortion
☐ Alcohol or substance abuse ☐ Mental health *(excluding psychotherapy notes)*

Note: *you must complete a separate form to authorize release of information related to HIV/AIDS. The NYS approved form can be found at http://www.health.ny.gov/diseases/aids/providers/forms/informedconsent.htm*

PART E: ACKNOWLEDGEMENT (PLEASE READ AND SIGN)

I understand that:

- I can revoke this authorization at any time by writing to the Health Plan at the address listed below except this revocation would not affect any action taken by the Health Plan in reliance on this authorization before my written revocation is received.
- Information disclosed as a result of this authorization may be re-disclosed by the recipient. Federal and state privacy laws may no longer protect my PHI.
- Health Plan will not condition my enrollment in a health plan, eligibility for benefits or payment of claims on my giving this authorization.

IMPORTANT: I have read and understand the terms of this authorization. I hereby authorize the use and disclosure of my protected health information in the manner described in this form. Unless you receive revocation in writing, this authorization will be valid until Health Plan completes activities outlined in Part C or until the date specified here: _____*MM/DD/YYYY*_____

Signature: _____ Date: _____

If this request is from a personal representative on behalf of the member, complete the following:

Personal Representative's Name: _____ Personal Representative's Signature _____

Description of Authority: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other *_____

**** You must provide documentation supporting your legal authority to act on behalf of the member***

Return form to: Excellus Health Plan, Inc. P.O. Box 21146 Eagan, MN 55121
or Fax: 315-671-7079

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.