INSTRUCTIONS FOR COMPLETING THE CONFIDENTIAL INFORMATION RELEASE FORM

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Please fill out this form if you would like Blue Cross® Blue Shield® of Arizona (BCBSAZ) to share your information with the person or entity you mention on the form. Each member who is 18 or older has to fill out and sign a separate form for each person/entity.

Why might you want BCBSAZ to share your information?

BCBSAZ has to keep your information private. You can choose not to fill out the form, and we'll still sign you up for a plan, provide benefits, and pay your claims. BCBSAZ needs this form if you want us to share your records with:

- Your spouse, parent, or child, so they can discuss claims questions with BCBSAZ
- Your broker, after you sign up for a health plan, so he/she can help with claims
- Your lawyer, for an injury case

How to Fill Out This Form

Tell us whose records we can share. Write the name of the BCBSAZ member this form is being completed for. Please include the group (if applicable) and member ID number.

Tell us who can get the records. This might be the name of a person, or it could be the name of a business, like a medical group, if you don't want us to send the records to a specific person.

Tell us which records we can share. Please check any applicable boxes in this section.

Tell us the purpose of sharing your records. Check at least one box.

Tell us when to stop sharing your information. You must check at least one box. If you check the box by "The date marked here," please write the date when we should stop sharing your information with this person or business. Check "No expiration" if you want the person or business to have access indefinitely. No matter which box you check, if you change your mind, you can also ask us to stop sharing your information at any time by writing to us.

Signature. If you are the member, print and sign your name and date the form.

Representative's Name/Signature. If you are signing the form because you are acting for the member, fill in your name, and sign and date the form. Include copies of any legal paper(s) that apply.

Questions? For questions about this form please call the number on the back of your ID card.

Please mail the completed form to:

BCBSAZ Attention: Enrollment
P.O. Box 13466, Phoenix, AZ 85002-3466

OR Fax: **602-864-4041**

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Use this form to let a person or entity get your information. This form is voluntary. You can choose not to fill out this form, and we'll still sign you up for a plan, provide benefits, and pay your claims.

Person Whose Information We Are Sharing:

Name:	
Date of Birth: / /	Phone Number:
Member ID:	Group Number:

Person/Entity Receiving Your Information:

Name/Entity:	
Address:	
City, State, ZIP:	
Email Address:	Phone Number:
Allow this individual to change: ☐ Address ☐ Bank Information	

Records We Can Share*:

☐ Precertification Information ☐ Billing/Payment Information ☐ Application, Enrollment, Eligibility
☐ Medical or Dental Records, Procedure & Diagnosis Codes ☐ Account Information ☐ Claim/Explanation of Benefits

*Some of these records may have details about contagious diseases, alcohol and drug abuse treatment, and genetic testing

Purpose:

☐ To help with claims or payments ☐ To assist with care coordination ☐ At my request

Tell Us When to Stop Sharing Your Information:

☐ The date marked here: / / ☐ No expiration

Note: You may tell us to stop sharing your records at any time. If you want us to stop sharing, write to us at:
BCBSAZ Privacy Office, Mail Stop C300, P.O. Box 13466, Phoenix, AZ 85002-3466
If you tell us to stop sharing, it will not change what BCBSAZ shared before you told us to stop.

Member Signature:	Date: / /
Representative's Name:	Relationship to BCBSAZ Member:
Representative's Signature:	Date: / /

Note: If you are asking us to share records for someone other than yourself, attach a copy of any legal paper(s) that apply.

If you tell us to share your records with someone, the person who gets your records may not keep them private. Your records won't be protected anymore under federal privacy laws.

Please mail the completed form to:

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P.O. Box 13466, Phoenix, AZ 85002-3466
OR Fax: **602-864-4041**
OR Email: **PrivacyOffice@azblue.com**

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