AUTHORIZATION FOR RELEASE OF RECORDS OR INFORMATION

SECTION A: I authorize the disclosure of my personal health information as described in Section B below. I understand this authorization is voluntary and made to confirm my directions. I hereby give my permission to the following Plan (________________________________) to disclose my personal health information in the manner described herein.
(Insert Plan Name)

Name: ____

Address: ____

Telephone: __________________________ Member Number: __________________________

SECTION B: Personal Health Information to Be Disclosed: Describe the personal health information you are authorizing to be used and/or disclosed:

____

____

____

Persons/Entities Authorized to Receive and Use: Name or specifically describe the persons and/or entities to whom you are authorizing the plan named above to disclose or let use the personal health information described above:

____________________________________ ____________________________________

Purpose of the Disclosure: The disclosure is being made for the following reason:

____

Right to Revoke: I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke it, this authorization will expire one (1) year after the date on which the authorization is signed. To revoke the authorization, I will contact **HIPAA Privacy Office, 10455 Mill Run Circle, Owings Mills, Maryland 21117, Mailstop: PMG-08**.

SIGNATURE:

I, ____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the plan named above. I understand that, by signing this form, I am confirming my authorization that the plan named above may use and/or disclose to the persons and/or organizations named in this form the nonpublic personal health information described in this form.

Signature: ________________________________ Date: __________________________

Witness: ________________________________

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: ____

Relationship to Individual: ____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

NOTICE TO RECIPIENT OF INFORMATION:

This information has been disclosed to you from records the confidentiality of which may be protected by Federal and/or State Law. If the records are so protected, Federal regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization 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.

Authorization for Release of Records or Information Form (*Authorization Form*)
INSTRUCTIONS

This form is to be completed by members who wish to allow other individuals to receive information about their medical or claims records.

- The *Authorization Form* is valid for one year from the date you sign the form.
- You will need your membership card to complete the *Authorization Form*.

Section A

On the third line, in the blank space for "**Insert Plan Name**", please write the plan name listed on your membership card. For example, BlueChoice, FreeState and Blue Preferred are samples of plan names. If there is no plan name on your card, write CareFirst in the plan name space.

Please provide the member name, address, telephone number and member number in the spaces provided.

Section B

In the "**Personal Health Information to Be Disclosed**" section, write the specific personal health information to be released. For example, "The medical records related to my hip surgery in June 2002," or "All my medical records," or "all of the records related to my heart problems."

In the "**Persons/Entities Authorized to Receive and Use**" section, specify the individual, organization or institution to whom you are releasing information. For example, "my broker John Doe," "my granddaughter Jane Doe."

In the "**Purpose of Disclosure**" section, explain why you are releasing your personal health information. For example, "to answer questions about my claims."

The "**Right to Revoke**" section allows you to stop the authorization for release of records anytime during the year after the form is submitted. To revoke your *Authorization Form*, write a letter that includes your name, member number, your statement that you want to discontinue the release of information, and the name of the people/institutions who you want to no longer have access to your information. If you decide to revoke your authorization, then please fax or mail your letter to the address noted below.

Signature Section

Please remember to sign and date the form before sending it in or we will not be able to use it.

Please mail or fax the completed Authorization for Release of Records or Information Form to the address or number noted below.

HIPAA Privacy Office
Mail stop HIPAA PMG-08
10455 Mill Run Circle
Owings Mills, MD 21117
Fax: 410-964-5252