

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Full Name _____

Regence ID# _____ Date of Birth _____

I authorize Regence BlueCross BlueShield of Utah (Regence BCBSU), Regence ValueCare, Regence HealthWise, and Regence Life and Health Insurance Company (Regence Life and Health) to disclose the following information:

- Enrollment and eligibility information
- Medical records and diagnosis*
- Psychotherapy notes*
- Claims, claim status, and claim history*
- Premium and billing information
- Other _____

Regence BCBSU, Regence ValueCare, Regence HealthWise and Regence Life and Health are authorized to disclose the information identified above to the following person(s) or entity(ies):

Name _____ Name _____
 Address _____ Address _____
 Phone (_____) Phone (_____)

The purpose of this disclosure is: to assist me with my health plan
 other _____

This authorization is valid for two years from the date of my signature or until _____
_____ (cannot exceed two years from date of signature).

I may cancel this authorization at any time by sending written notice to Regence, P.O. Box 30270, Salt Lake City, UT 84130-0270. Cancellation of this authorization will not affect any actions taken by the entities authorized above before receiving my cancellation notice.

I understand completing this authorization is not a condition to receive treatment, payment or eligibility. Regence BCBSU, Regence ValueCare, Regence HealthWise and Regence Life and Health are not responsible for any action taken by an authorized recipient of my protected health information. I am aware that an authorized recipient may redisclose my information and the privacy protections provided by law may be lost.

▶ _____
Signed _____ Dated _____

If this authorization is signed by a person acting on behalf of another person, please complete the following and attach documentation demonstrating your authority to act on behalf of another.

Name of Personal Representative (please print) Phone (_____) Relationship _____

▶ _____
Signature of Personal Representative

* Note: Information about claims, medical records, diagnosis, and psychotherapy notes may contain sensitive data, including data related to treatment of chemical dependency, sexually transmitted disease, HIV/AIDS, mental health, and reproduction or contraception. **DO NOT** check the boxes authorizing the disclosure of claims, medical records, diagnosis, or psychotherapy notes if you do not want information relating to these sensitive conditions released.



Independent Licensees of the Blue Cross and Blue Shield Association

Please return completed form to: P.O. Box 30270, Salt Lake City UT 84130-0270.