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 company you mention on the form. **Each member who is 18 or older has to fill out and sign a separate form.**

Why Might You Want BCBSAZ to Share Your Records?

BCBSAZ has to keep your information private. 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 What Records We Can Share: Check at least one box.

Tell Us Whose Records We Can Share: Write the name of the BCBSAZ member this form is for. This is usually your name.

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 Why You Want Us to Share Your Records: Check at least one box.

Change My Records: Tell us if the person can change your address or bank account information. Note: This part of the form is optional.

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. If you don't have a specific date, check the 90-day box. 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 our Privacy Office.

BCBSAZ Member's ID Number: Enter the BCBSAZ ID number of the person whose records will be shared. If you do not know the ID number, use the Social Security number or Medicare Beneficiary Identifier (MBI).

Signature: If you are the member, print and sign your name and date the form. If you are not the member, have the member print and sign their name.

Group Name and Number: If you have coverage through your work, you are in a Group plan. Enter the name and number of your Group health plan if this applies.

Representative's Name/Signature: If you are signing the form because you are acting for someone else, fill in your name, and sign and date the form. Include copies of the legal papers that apply.

Questions? For questions about the form, please call **602-864-2255** or **1-800-232-2345, ext. 2255 (TTY: 711).**

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Use this form to let a person or firm get your information, except HIV information. We have a different form for HIV information. You can also use this form to let them change your address or bank information. Even if you don't sign this form, Blue Cross® Blue Shield® of Arizona (BCBSAZ) will still pay your claims, sign you up for our plan, and let you be eligible for benefits. This form is not required.

Tell Us What Records We Can Share: BCBSAZ can give out what is marked below. Some of these records may have details about contagious diseases, alcohol and drug abuse treatment, and genetic testing *(check all that apply):*

- ☐ Application, enrollment, eligibility information
- ☐ Claims/Explanation of Benefits information
- ☐ Precertification information
- ☐ Billing/payment information
- ☐ Medical or dental records, procedure & diagnosis codes
- ☐ Account information
- ☐ Other *(please explain)* ______________________

Tell Us Whose Records We Can Share:			
Tell Us Who Can Get the Records:			
Name	Company Name		
Address	City	State	ZIP Code

Note: 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.

Tell Us Why You Want Us to Share Your Records *(check all that apply):*

☐ To help get a healthcare policy ☐ To help with claims or payments ☐ At my request

☐ Other reason *(please explain):*

Change My Records:

I also want to let (name):	☐ Change my address ☐ Update my bank information

Tell Us When to Stop Sharing Your Information:

☐ 90 days after the health plan ends ☐ The date marked here (MM/DD/YYYY): ☐ No expiration

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 Name	BCBSAZ Member's Identification Number
Member Signature	Date Signed (MM/DD/YYYY)
Group Name (if this applies)	Group Number (if this applies)
Representative's Name*	Relationship to BCBSAZ Member

*If you are asking us to share records for someone other than yourself, please tell us why you can do this. Also, attach a copy of any legal paper(s) that apply.

Please send us your filled-out, signed form by either mail or fax.

Medicare Advantage Members and Applicants	**All Other Members and Applicants**
Mail: BCBSAZ Attention: Enrollment P.O. Box 29234 I Phoenix, AZ 85038 **Fax:** 602-544-5638	**Mail:** BCBSAZ Attention: Enrollment P.O. Box 13466 I Phoenix, AZ 85002-3466 **Fax:** 602-544-5661

If you'd like a copy of your signed form, call the Privacy Office at **602-864-2255** or **1-800-232-2345, ext. 2255 (TTY: 711).**

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified interpreters and written information in other formats such as large print and accessible electronic formats. We also provide free language services to people whose primary language is not English, such as qualified interpreters and written information in other languages.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-446-8331 (TTY: 711).

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká' ánída' áwo' dę́ę́, t'áá jiik'eh, éí ná hólǫ́, kojį́ hódíílnih 1-800-446-8331 (TTY: 711)

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